“MARRIED, SINGLE, OR GAY?”

QUEERYING AND TRANS-FORMING THE PRACTICES OF ASSISTED HUMAN REPRODUCTION SERVICES

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Abstract

Lesbian, gay, bisexual, trans, and queer (LGBTQ) people in North America have historically been categorized as “disfavoured reproducers” and, through various legal, social, and political means, have been denied the right to parent. The past 30 years, however, have been marked by staggering social, legal, and political change in relation to LGBTQ families and people across the LGBTQ spectrum in Canada are increasingly making use of Assisted Human Reproduction (AHR) services as part of their family-building processes.

However, despite significant gains in social and legal recognition for LGBTQ people in Canada, LGBTQ people are often unhappily marginalized when they seek reproductive assistance and are brought under the rubric of a highly medicalized, profit-making system within which their bodies, and families, most often do not fit.

Drawing on 40 qualitative interviews from the CIHR-funded Creating Our Families project, which was designed to explore the experiences of LGBT people with AHR services in Ontario, this dissertation explores the ways that LGBTQ identities and kinship structures are often misrecognized and, in many cases, unintelligible in the fertility clinic context. The assumptions of the heterosexual matrix, in alliance with the culture of the fertility industry, can result in violations or ruptures to the personhood of queer and trans people as they make their way through the clinic. The strategies that people adopt in order to enhance their flow through the clinic can at times contribute to these violations.

The dissertation explores the contours of a more ethical relation between LGBTQ people and fertility clinics, and finally, considers some pedagogical issues related to what is at stake when health care providers are asked to adopt a stance of “not-knowing” that recognizes the radical alterity of the Other.

To Dr. Norman Epstein, my dad

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Chapter 1: Background / Theoretical Framework / Methodology

Some Personal History

I got pregnant in 1991 with the assistance of a sperm bank and a fertility clinic. After making our initial appointment with the clinic, my female partner and I received a letter in the mail addressed to Mr. and Mrs. Epstein, informing us that "Since Infertility is a problem that affects couples, your appointment has been made for both partners. You will both be interviewed and examined and a plan of management will be defined." On the day of our appointment the doctor suggested that if we found our own sperm donor he would happily provide cycle monitoring (daily blood work and vaginal ultrasounds to determine the time of ovulation), and then send us home to inseminate in the old-fashioned lesbian way (turkey baster or, more practically, syringe — without the needle). But, alas, that known donor did not materialize so we made the decision to choose a sperm donor from the catalogue and to do cycle monitoring *and* insemination at the clinic.

Choosing a donor was not simple because my partner and I were both Jewish and we wanted a Jewish donor. I believe there were three to choose from, none of whom matched the physical characteristics I wanted (dark hair and eyes like me), but we chose one anyway. Later we discovered that two other queer women in a support group I had been attending, also seeking a Jewish donor, had selected the same donor and that our children, all born within a year of each other, were donor siblings — a fact we disclosed to our three offspring 18 years later. The phenomena of "donor siblings" is, of course, common in heterosexual communities as well, and, in fact, a website known as the Donor Sibling Registry has now been established to assist donor siblings to find each other (www.donorsiblingregistry.com). However, LGBTQ communities tend to be much more socially overlapped, and so the experience we had of our children knowing each other and, in a sense, growing up together, is a much more common occurrence.

But back to the fertility clinic. Those who have had the fertility clinic experience are familiar with the routine of the early rise, the (in my case) bike ride to the clinic, the waiting room filled with parent wannabes, and the long daily waits for blood tests and ultrasounds. The hope that you will be pricked by the one who hurts least, the hope that the follicles on the ultrasound screen will produce fertile eggs and, of course, the hope that the insemination will result in a pregnancy. In my case, given that I did not ovulate until day 54 of my cycle (14 is average), I was there for many mornings, anticipating ovulation.

The fertility clinic experience worked for me. I embraced the morning cycle and immersed myself in a book while I waited to be poked and prodded. I was grateful for the technology that could pinpoint my ovulation, something I was unable to do myself. When I was shown the swelling follicles on the ultrasound I felt almost pregnant and called my partner triumphantly. And when I did actually get pregnant on my second try, despite a (probably inaccurate) diagnosis of Polycystic Ovarian Syndrome, I was ecstatic. Of course I did have to stand firm against the doctor’s suggestion, after the first insemination attempt, that I take Clomid (a first-line fertility drug that, among other side effects, increases one’s chances of multiple births) to make things simpler for everyone. And, as I lay spread-eagle in the stirrups awaiting insemination, he told me that “they had had others like me in their clinic.” I was not sure exactly what he meant. Lesbians? Single women? Women over 35? Jews? With hairy legs? It’s hard to know. On the second insemination he asked my partner if she would like to perform the act, pushing the sperm down the tube to near my cervix. However, she was too busy watching the sperm swimming on the monitor he had in his office, to even hear his offer. “Look at those sperm," he announced proudly, "we freeze sperm better than anyone in North America! Look at that motility, look at them swim!" He seemed proud of all the babies he had made. My daughter, conceived with an anonymous sperm donor, is now 22 years old.

In 1997, I was approached by the midwife who attended my daughter's birth. She asked if I would develop, with her, a course for lesbian, bisexual, and queer (LBQ) women considering parenthood. Dykes Planning Tykes was born. The course, which originated as a seven-week course, run through the Queer Exchange, a community-based program sponsored by the Centre for Lesbian and Gay Studies, has now expanded to 12 weeks long. It is institutionalized as a partnership between the LGBTQ Parenting Network at the Sherbourne Health Centre and Queer Parenting Programs at The 519 Church St. Community Centre in Toronto, and has spawned three other queer and trans family-planning courses: Daddies and Papas 2B; Trans-Masculine People Considering Pregnancy; and Queer and Trans Family Planning(s). Dykes Planning Tykes has now run more than 30 times over the past 16 years, with close to 700 participants.

In 1997, as part of the first Dykes Planning Tykes course, some friends and I developed and performed an interactive Forum Theatre script about a lesbian who, unable to find a man willing to act as a known sperm donor, turns to a clinic to get pregnant, only to be refused service by the doctor. Forum Theatre is a method developed by Brazilian theatre director and activist, Augusto Boal (1979). It encourages people, through participatory theatre, to actively explore and analyze their realities in order to become effective actors in their own lives. In this case we had people stopping the action and entering the scene attempting to convince the doctor that he should grant lesbians access to insemination services. At the time, this was not an unlikely argument. In the early 1990s, 19 out of 33 assisted insemination programs surveyed by the Royal Commission on

New Reproductive Technologies would refuse lesbians' "treatment at the clinic" (Royal Commission on New Reproductive Technologies, 1993, p. 454)

Some LGBTQ Parenting History

The past 30 years have been marked by staggering social, legal, and political change in relation to LGBTQ families (Epstein, 2012), including significant change in the practices associated with LGBTQ reproduction. Thirty years ago lesbians and gay men were losing their children in court (Mackay, 1982; Chesler, 1986) and fertility clinics either denied services to those outside of the heterosexual, cisgender (non-trans) norm, or required that one jump through gatekeeping hoops such as a "letter to the doctor" or a psychiatric assessment, in order to gain access. At play were a series of arguments, originally developed as fuel in the 1970s and '80s custody cases that found lesbians and gay men to be "unfit" parents (Pollack, 1990). LGBTQ people and their allies have spent decades rebutting these arguments (Epstein, 2003, 2012) but such views continue to circulate in ways that profoundly affect the daily lives, institutional encounters, and sense of entitlement to parent among LGBTQ people. However, people across the LGBTQ spectrum in Canada are increasingly making use of services offered by fertility clinics as part of their family-building processes. LBQ women began appearing at clinics in the early 1990s, mostly to gain access to donor sperm and insemination and sometimes to make use of IVF technology as a means to create a "biological" connection to two parents. More recently queer women have been joined by gay, bisexual, and queer (GBQ) men who require IVF technology as part of surrogacy arrangements, and by trans women and men who, depending on where they are in a transition process and the implications of this for fertility, are accessing clinics to freeze gametes (sperm/eggs) or to achieve pregnancy. Sometimes people simply want to monitor their cycles (an accurate way of identifying the time of ovulation), in order to inseminate at home, and, of course, some LGBTQ people experience the fertility problems that the clinics were set up to address. In Toronto, some fertility clinics estimate that as many as 15 to 25 percent of their clients are from LGBTQ communities (Epstein, 2008).

The broad set of technologies developed to assist and monitor conception and pregnancy were initially referred to as "reproductive technologies" (RTs) or, in the early years of their development, as "new reproductive technologies" (NRTs). More recently the services offered by fertility clinics are commonly referred to as Assisted Human Reproduction (AHR) services. Here I use RTs when I refer to the technologies themselves, and AHR when I am referring to the services offered by fertility clinics.

Historically, decisions about who should and should not be allowed to access AHR services were made based on a "best interests of the child" approach, similar to that which frames most adoption practices, and reminiscent of the arguments that framed early lesbian custody cases. This model evaluates some people as "better," "more appropriate," and "more deserving" parents, and some family configurations as closer to "normal," often because they are deemed more "natural." The term "stratified reproduction," was first articulated in 1995 by Shellee Colen in a piece on West Indian caregivers (Ginsburg & Rapp, 1995). By "stratified reproduction," Colen refers to the social, economic, and political processes by which "physical and social reproductive tasks are accomplished differentially according to inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status" (p. 78). The term conceptualizes arrangements "by which some reproductive futures are valued while others are despised" (p. 3), and is useful in explorations of LGBTQ parenting because it gestures toward the ways that, in the world of reproduction and parenting, some people are seen as "ideal" parents and others as "unfit" parents.

LGBTQ people in North America have historically been categorized as what Thompson (2005) calls "disfavoured reproducers." Through various legal, social, and political means we have had children taken away from us and have been disentitled from becoming parents. In the everyday world of reproduction the heterosexual nuclear couple (who can produce "naturally," and who are therefore, "normal") is privileged, while lesbian, gay, bisexual, transgender, and queer (LGBTQ) parenthood (among others) has historically been discouraged, denigrated, and, in many cases, denied. Thus, the experience portrayed in the Forum Theatre piece we performed at the first Dykes Planning Tykes session, of a queer woman being denied access to reproductive services, was common in many North American settings until the mid-1990s.[1]

In more recent years, access to AHR services for LGBTQ people has been facilitated by a gradual shift in the criteria for access to reproductive technologies from a model that centres the "best interests of the child" to one that is more about adult rights — the adult citizen's right to reproduce (Thompson, 2005; Mamo, 2007). This shift has also been hastened by the fact that AHR services, for the most part and increasingly, are deeply embedded in a system of commercialized biomedicine that operates fundamentally from a profit motive. Mamo (2013), in a recent self-authored response to her 2007 work, raises important questions about queer involvement with this industry. She argues that queer and trans people have become "parents-in waiting," having been granted access to an ever-expanding international on-line trade in human sperm, eggs, and wombs, and the "panoply of biomedical services that rely on third and fourth

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[1] For discussion of issues of access by and discrimination towards LGBTQ people in AHR services see Amato & Jacob, 2004; Baetens & Brewaeys, 2001; De Sutter, 2001, 2009; Gurmankin, Caplan, & Braverman, 2005; Greenfield, 2007; Greenfield & Seli, 2011; Murphy, 2010; Peterson, 2005; Stern, Cramer, Garrod & Green, 2001.

parties" (p. 233). Reminiscent of early feminist writings on RTs, she raises issues of bioethical ethics in the face of queer movement from the margins to the center of Fertility Inc. (a term Mamo and others have used to describe the corporate, profit-making enterprise of fertility services in North America). She asks:

> Who will provide the eggs and the wombs necessary to enable these family forms? From what towns, communities, and countries will the bio-materials be drawn? From whose gendered, raced, and classed bodies will they be drawn? Will these services follow capitalism from the west to the rest to secure the bodies and labor necessary to fulfill our American Dreams? How can we be accountable to these collaborative reproducers? And…*where are queer practices, queer bodies in these debates*? (Mamo, 2013, p. 235)

These are hugely significant questions that require serious attention from queer and non-queer "parents-in-waiting" alike. At whose expense do some become parents, while others are excluded from parenthood or serve to provide the gametes and reproductive services necessary for still others to become parents? Under what conditions and dynamics of power do these interactions take place?

Fertility Inc. does not necessarily differentiate (or care) from whom the buck flows. Currently the primary obstacle to access to AHR services in North America is financial; AHR services are set up to serve those who can pay for them, resulting in highly stratified access, particularly along lines of class and race. In the early 1990s queer people came knocking on the doors of fertility clinics who, confronted with a supply of services that was outweighing demand, let them in as paying customers.

However, the history of queer entry into the world of AHR has not been a smooth or unified one. Despite an increased clientele who are forming non-normative families, AHR services remain profoundly heteronormative spaces. They were established to assist cisgender, heterosexual, financially resourced couples who are experiencing "infertility," and these are the people who continue to be imagined as the "appropriate" and ultimately, "deserving" users or what Mamo (2007, p. 133) calls the “configured users” of AHR services. A quick look at the images on clinic websites, or in fertility industry magazines (see for example, *Creating Families*, the magazine of the Infertility Awareness Association of Canada at www.iaac.ca) makes it clear who the imagined users are: white, cisgender, heterosexual couples with money and good looks.

As a result, LGBTQ people (many of whom *are* good looking, but lack the other criteria) are often unhappily marginalized when they seek assistance within AHR systems and are brought under the rubric of a highly medicalized, profit-making system within which their bodies, and families, most often do not fit. While lesbian, gay, and bisexual people are more routinely accessing AHR services, trans-identified people are currently being subjected to debates in AHR circles about their right and/or abilities to parent, and subsequently, to whether or not they should be served by AHR practitioners (Pyne, 2012; see also Baetens, Camus, & Devroey, 2003; Brothers & Ford, 2000; Buckett, 2011; De Sutter, 2001a, 2001b, 2002, 2003; Jones, 2000).

Reminiscent of and overlapping with the arguments used to discredit LGB people as parents (i.e., concerns about sexual immorality, promiscuity, and abuse; that children will be confused about gender and/or develop a homosexual orientation themselves; that children will lack properly gendered “role models”; that children will be subjected to stigma and hostility from their peers), these arguments focus particularly on the “anti-social” and “aberrant” behavior of trans people (Jones, 2000 cited in Pyne, 2010, p. 22), the instability of trans people, particularly trans women (Baetens et al., 2003; Buckett, 2011), and the recommendation that trans people have “completed” a transition before becoming parents — although the author does support the rights of trans people to have children (De Sutter, 2001b). Baetens, Camus, and Devroey (2003) also note the high levels of discrimination that trans people face as a possible reason to restrict trans people’s access to AHR. Pyne (2010) points out the lack of empirical evidence to support these claims, the ambiguity about what it means to "complete a transition," and "the paradox inherent in denying a social right on the basis that one has been damaged by the denial of social rights" (pp.11-12).

Despite these debates trans-identified people *are* joining LGB people in accessing fertility clinics, although barriers to access continue to operate in more subtle ways for LGBTQ people across the board. These include lack of information on clinic websites and promotional materials (Johnson, 2012), compulsory counselling sessions (the purpose of which is unclear), clinic forms and practices that do not allow for LGBTQ identities and/or family structures, and policies that act as barriers to LGBTQ family structures. For example, the semen regulations in Canada permit insemination with fresh (i.e., not frozen) sperm only from a "spouse" or "sexual partner," but otherwise require sperm to be frozen and quarantined for six months, a process which necessitates delays and a financial burden.[2]

Working for Change

But, you might ask, haven't the practices of clinics changed at all to accommodate this new group of users? What actually is happening when LGBTQ people enter these profoundly cisgendered, heterosexual spaces? What research and community knowledge exists to describe and/or analyze these encounters? And what kinds of educational initiatives and/or approaches might lead to effective change in clinic environments?

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[2] Health Canada Directive: Technical Requirements for Therapeutic Donor Insemination, July 2000. http://www.hc-sc.gc.ca/dhp-mps/brgtherap/applic-demande/guides/semen-sperme-acces/semen-sperme_directive-eng.php

For more than 15 years I have worked in a research partnership with Dr. Lori Ross who leads the Re:searching for LGBTQ Health team at the Centre for Addiction and Mental Health in Toronto. We have collaborated on several major research projects, with her acting as the "academic partner" while I am the "community partner," in my capacity as coordinator of the LGBTQ Parenting Network, a well-established community development project that works with and on behalf of LGBTQ parents, prospective parents, and their families (see www.lgbtqparentingconnection.ca). The projects have been based on a community-based research model, with both of us, and sometimes other partners, actively involved in research design, data analysis, and knowledge mobilization.

In 2003 Dr. Ross and I, along with Dr. Leah Steele (St. Michael's Hospital, University of Toronto), conducted a study of LBQ women's experiences of preconception, pregnancy, and the first year of parenting. Among other things, the research resulted in two articles in high-impact fertility industry journals: *Fertility and Sterility* (Ross, Steele, & Epstein, 2006a) and the *Canadian Journal of Obstetrics and Gynecology* (Ross, Steele, & Epstein, 2006b). In these articles we formulated a series of recommendations for AHR practitioners looking to improve the quality of their services to LBQ women. (See Appendix A.)

These findings and recommendations were presented at the annual meeting of the Canadian Fertility and Andrology Society (CFAS) in 2007, and condensed into a fact sheet that was distributed to clinics across the country. One of the strongest recommendations, based on participant interviews, was the need to train and educate staff in LGBTQ culture. Since that time my colleagues and I have conducted training sessions with most of the major downtown Toronto clinics and presented at rounds to OB/GYN departments of several downtown Toronto hospitals. I have also sat on committees of the Assisted Human Reproduction Agency in Ottawa, written a position paper, with others, on LGBTQ concerns with the Assisted Human Reproduction Act, and advocated at individual, local, provincial, and federal levels for the inclusion of LGBTQ people and families in the reproductive agenda of the country and in the daily practices of AHR services.

In 2010 we received a Canadian Institutes of Health Research (CIHR) grant (through a special call for proposals relating to the Psycho-Social Aspects of AHR) to conduct a pilot study of LGBTQ experience with AHR services in Ontario. The study, entitled Creating Our Families (COF), was conducted as a partnership between Dr. Lori Ross of the Re:searching for LGBT Health Team at the Centre for Addiction and Mental Health; Dr. Leah Steele, St. Michael's Hospital; and myself, Coordinator of the LGBTQ Parenting Network, Sherbourne Health Centre. We later added another investigator, Stu Marvel, from Osgoode Hall Law School, York University. Several research assistants and students also worked on the project. We conducted a total of 40 interviews with 66 lesbian, gay, bisexual, trans, and/or queer people across Ontario, who had either used or considered using AHR services since 2008.

In the course of these interviews we heard many complex stories that included descriptions of clinic encounters that were experienced as disappointing, frustrating, and, in some cases, extremely troubling. People described feeling invisible, unheard, angry, scared, and/or anxious. We also heard stories from people who were grateful for the services they were able to access and, in some cases, who were happy overall with the treatment they received at clinics. Sometimes people's accounts seemed linked to the expectations they held going in and/or to the strategies they adopted in advance of or in response to clinic encounters. Many people told stories that were a mixture of appreciation, frustration, and a myriad of other sentiments.

The final question we posed in the interviews was "If you could have five minutes with someone who could really make change in the AHR system, what would you want to say to them?" A summary of people's responses to this question was written up in an article that was submitted to *Fertility and Sterility* (See Ross et al., 2014 for a version that was eventually published in the *Journal of Obstetrics and Gynaecology Canada*). The journal rejected it with a short comment: "A very interesting paper but with limited data provided and the overall recommendations to improve practice are fairly self-evident (training, inclusion of alternative families in clinic materials, etc.). While the inclusion of men and trans people is a strength, the vast majority of participants are women (who have been previously studied with similar results)."

This rejection was frustrating because although the recommendations are "self-evident," they have, for the most part, not been implemented or, it seems, taken overly seriously by clinics. Perhaps repetition is required. Or perhaps, given that there continues to be a regular stream of LGBTQ clients lining up at fertility clinic doors, the clinics are not feeling compelled to change their practices since they have no impact on their bottom line. For whatever combination of reasons, those interviewed in 2010 reiterated things interviewees said in 2003 because the practices of clinics have not significantly changed, despite increased access to clinics by LGBTQ people, significant gains in social and legal recognition for LGBTQ people in Canada generally, and despite our team's publications in leading journals, training in clinics, presentations at conferences, and many people's advocacy at all levels. Of course, change happens slowly, inconsistently, and unpredictably. But how is it that we can receive an eager, engaged, and sincere response from a group of Toronto clinic staff, including doctors, nurses, lab technicians, counsellors, clinic managers, and receptionists at a training session, and then the next day (or week or month) attend a conference where one of the physicians in a session makes a remark clearly illustrating that he missed the point—and that we continue to hear repeated stories from LGBTQ people complaining about the forms, language, and assumptions embedded in their AHR treatment and about feeling marginalized, invisible, disrespected, and sometimes belittled in their interactions with clinics?

Of course there are many answers to this question. Institutional change and education are always non-linear, unpredictable, and complex. Britzman, in her 1998 essay on queer pedagogy, addresses some of the difficulties and complexities of "anti-homophobia education" that, in its focus on an empathic approach to the "other," may in fact actually reproduce the difference it aims to overcome (1998, p. 87). Similarly, outcomes of "cultural competency training" (a term that needs some deconstruction in my view, since it implies it is possible to become "competent" in another's culture) are inconsistent and difficult to measure. Advocacy efforts often fall on the unlistening ears of bureaucrats; clinic staff leave to work elsewhere; and old habits die hard.

The Current Project

This project draws on the data generated from the COF interviews to explore, in more depth, the dynamics of LGBTQ interactions with fertility clinics. While others have written about the workings of fertility clinics in relation to heterosexual couples (Thompson, 2005) and lesbians (Mamo, 2007), I expand this area of study by exploring the negotiations that take place between trans-identified people and LGBTQ people in non-normative family configurations with AHR systems, specifically lesbians and their known sperm donors, as well as those who undertake reciprocal IVF (an egg is retrieved from one person, fertilized and implanted in another). I approach this data with the following research questions:

- How do LGBTQ people, whose bodies, identities, and kinship systems are often not intelligible within the biomedical world of AHR, negotiate the discursive and institutional practices of these systems?
- How does LGBTQ entry into the biomedical world of AHR serve to disrupt and/or reinscribe normative discourses, power, and social relations with regard to sex, gender, and kinship?
- What is at stake in the land of assisted human reproduction when LGBTQ people enter the scene? What would a more ethical relationship between LGBTQ people and AHR services look like and how might this inform educational strategies in this, and other, sectors?

I have chosen the themes of sex/gender and kinship because it is under the rubric of these categories that LGBTQ bodies, sexualities, gender identities/expressions, kinship systems, and family configurations, in their interactions with AHR services, confront a system in which they do not fit. In the chapter on sex/gender (chapter 3) I look to the narratives of trans-identified people to explore questions related to the intelligibility of sexed and gendered bodies in the fertility clinic setting. What happens when well-meaning clinic staff confront bodies and identities that are unintelligible to them? How do those who are not intelligible negotiate this lack of recognition? Similarly, in the chapter on kinship (chapter 4) the narratives of non-normative queer women-led families inform an exploration of the intelligibility of LGBTQ kinship systems and family configurations in the AHR setting. The final chapter explores the possibilities for a more ethical relationship between LGBTQ people and AHR services, and addresses issues of education in professional settings. It explores possibilities for educational strategies that might account, in a more meaningful way, for what is at stake when LGBTQ bodies, identities, and kinship structures encounter the bio-medical world of AHR.

Theoretical Framework

Like every researcher/writer I come to this project with assumptions about the nature of the social world. Here is my attempt to articulate the assumptions I make and their implications for this project.

My view of social relations, interactions, power, and social change relies heavily on the work of Michel Foucault, while also drawing on feminist and critical theory, as well as queer theory and trans studies. Having grown up immersed in and heavily influenced by Marxist/socialist/anarchist views of power and resistance, it is difficult for me to completely move away from theoretical frameworks that suggest a structural view of power. However, my experience both as a community organizer/activist and as a professional mediator and teacher of communication skills, has shown me, time and again, that power does not operate in simple, linear, or dualistic ways, and that simplistic formulations of power often lead to simplistic, short-lived, and not-so-effective strategies for social change. And so I have come to embrace a more Foucauldian-influenced stance that views power not as a simple and unidirectional force but as circulating in social relations—as both productive of subjectivities and of subjection, of constraints as well as of possibilities, and as operating through a proliferation of discourses. Foucault's conceptions of *power*, *subjectivity, discourse*, and *normalization* are key to the theoretical work of this project. At the risk of oversimplification, what follows is a brief summary of these concepts.

Foucault

Foucault conceives of power not as an overriding sovereign power, resting in the hands of certain individuals who impose it in a repressive, violent, and/or coercive manner on others, but rather as relational, as circulating in the social:

> Power is not to be taken to be a phenomenon of one individual's consolidated and homogeneous domination over others, or that of one group of class over others… Power must be analysed as something which circulates or rather as something that only functions in the form of a chain. It is never localized here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organization. And not only do individuals circulate between its threads; they are always also the elements of its articulation. In other words, individuals are the vehicles of power, not its points of application. (Foucault, 1980, p. 98)

Foucault was not interested in an overarching, global analysis of bourgeois power, but rather, in the more localized and unpredictable ways that power is enacted in specific settings, within particular sets of social relations. He was interested in what he called the "micro-mechanisms" of power and their workings within institutions:

> The role for theory today seems to me to be just this: not to formulate the global systematic theory which holds everything in place, but to analyse the specificity of mechanisms of power, to locate the connections and extensions, to build little by little a strategic knowledge (savoir)… the theory to be constructed is not a system but an instrument, a logic of the specificity of power relations and the struggles around them… this investigation can only be carried out step by step on the basis of reflection (which will necessarily be historical in some of its aspects) on given situations. (Foucault, 1980, p. 145)

Key to this understanding of power, are the concepts of "discourse" and "subjectivity." To Foucault, discourses and discursive practices delineate what is accepted as "reality," what can be "said," in a given historical moment in a particular society. Discursive practices not only "say" things, but they "do" things, establishing what he called regimes, or effects, of truth:

> Now I believe that the problem does not consist in drawing the line between that in a discourse which falls under the category of scientificity or truth, and that which comes under some other category, but in seeing historically how effects

> of truth are produced within discourses which in themselves are neither true nor false. (Foucault, 1980, p. 118)

Discourse, and the ways that power circulates in discourse through identifications and disidentifications, also works to constitute human beings as “subjects,” with “identities,” creating subjectivities based in regimes or effects of truth:

> In fact, it is already one of the prime effects of power that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals. The individual, that is, is not the *vis-à-vis* of power; it is, I believe, one of its prime effects. The individual is an effect of power, and at the same time, or precisely to the extent to which it is that effect it is the element of its articulation. The individual which power has constituted is at the same time its vehicle. (Foucault, 1980, p. 98)

Discourses, like power, are not simple or stable in their effects. They can “subject” human beings in ways that are limiting or constraining, and they also create possibilities for altered and unforeseen subjectivities and discursive practices. So, for example, in his analysis of the history of sexuality, Foucault describes how the social controls and institutional surveillance applied by psychiatry, the law, and literature to the area of “perversity,” also made possible the formation of a “reverse” discourse: “homosexuality began to speak in its own behalf, to demand that its legitimacy or ‘naturality’ be acknowledged, often in the same vocabulary, using the same categories by which it was medically disqualified” (Foucault, 1978, p. 101). To Foucault, discourses are not carriers of a stable sovereign power, but rather are the vehicles within which power circulates, creating both limits to truth and new truth possibilities:

> To be more precise, we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies…Discourses are not once and for all subservient to power or raised up against it, any more than silences are. We must make allowance for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possibly to thwart it. (Foucault, 1980, p. 101)

However, Foucault did not view power as “the best distributed thing in the world” (1980, p. 99). Instead he documented the infinitesimal mechanisms of the workings of power, and the historical shift from the power of the law to a disciplinary form of power that operates through techniques of normalization and institutions and apparatuses of surveillance. In Foucault’s analysis, the seventeenth and eighteenth centuries were marked by the development of a new form of power, what he called “bio-power.” Power had to

> gain access to the bodies of individuals, to their acts, attitudes and modes of everyday behavior… to grapple with the phenomena of population, in short to undertake the administration, control and direction of the accumulation of men. (Foucault, 1980, p. 125)

His *History of Sexuality, Volume 1* is largely concerned with the development of techniques for regulating populations through the disciplining of the body and the emergence of “norms,” that “produced a new subject and object of knowledge and a new target of power, namely, Man [sic]. As Rabinow (1984) puts it in his introduction to the *Foucault Reader,*

> An essential component of technologies of normalization is the key role they play in the systematic creation, classification, and control of “anomalies” in the social body… certain technologies serve to isolate anomalies… one can then normalize anomalies through corrective or therapeutic procedures, determined by other related technologies. In both cases, the technologies of normalization are purportedly impartial techniques for dealing with dangerous social deviations. (p. 21)

With the development of techniques of normalization came the Human Sciences and the bureaucratic welfare state, both designed to discipline bodies — not through a direct, legally based coercive form of power, but rather through statistical and bureaucratic methods attached to concepts of normalcy and deviancy. Bio-power operates in and through the social sciences, medicine, social work, psychiatry, education, prison systems— institutions designed to ubiquitously control populations through the establishment of norms and through their internalization in populations.

It is perhaps clear why these Foucauldian concepts are central to this project. Much of Foucault's later work centred on the historical development of categories of sexual deviancy, as well as analysis of the role of the "family" and medical institutions in policing these categories. Disciplining populations includes the establishment of norms related to sexuality, gender, reproduction, kinship, the family, and the connection of all of these spheres of life to the discourses and practices of biomedicine. LGBTQ people are brought into subjectivity through discourses of "homosexuality," and "gender identity," and our kinship systems and desires to parent are often in conflict with "norms" related to reproduction, family, sexuality, and gender. We live and breathe these forms of normalization in most areas of life, and both embody and contradict them in our interactions with medical and other kinds of service providers. My project aims to explore the micro-mechanisms of power as they are negotiated in the fertility clinic context.

Sex/Gender

There exists a rich and vast feminist scholarship on questions of sex and gender — how they should be conceived and how, as concepts, they relate to one another (see Risman & Davis, 2013). As Pascoe (1995) points out, the term *gender* dates back to at least the fourteenth century. Writing in the 1990s, Pascoe dates the contemporary scholarly use of the term to the 1970s, when "path-breaking feminist scholars began to distinguish between the biological characteristics they labeled 'sex' and the attitudes, behaviours, and social structures they labeled 'gender'" (1995, p. 273). Anthropologist Gayle Rubin (1975) famously called it the "sex/gender system" and encouraged an examination of the ways in which biological sex was transformed culturally into social gender. Feminist scholars across disciplines took up this challenge (Pascoe, 1995, p. 273). In the 1980s Rubin extended this questioning of the “natural” to an exploration of sexuality, arguing that “sexuality,” like “gender” was culturally constructed. And in the 1990s scholars began to suggest that even the categories of biological sex difference might, in fact, be culturally constructed (see Butler, 1990; Laqueur, 1990).

In 1987 West and Zimmerman published a pivotal essay in which they argued that gender is something we *do* more than something we *are.* They distinguished sex, sex category, and gender from one another, and suggested that recognition into a particular sex category requires appropriate gendered behaviour (clothes, hair, behaviour)—that gender is something produced through “required identificatory displays” (West & Zimmerman, 1987, p. 127). This concept of “doing gender” has had an enormous impact on sociological and feminist explorations of gender, and I will draw on some of this literature in this project. People have written about *Doing Gender* (West & Zimmerman, 1987), *Accounting for Doing Gender* (West & Zimmerman, 2009), *Doing, Undoing, or Redoing Gender* (Connell, 2010), and *Doing Gender, Doing Heteronormativity* (Schilt &Westbrook, 2009), among others. Of particular interest is some recent work by Jane Ward (2010), in which she develops the term “gender labour,” to describe work done, beyond achieving one’s own gender coherence, in order to help *others* achieve the varied forms of gendered recognition they long for. Her work is based on interviews with feminine subjects in femme/FTM sexual relationships, and explores how gender subjectivities are constituted through the labours of intimate others. This notion of the work required of others in order to assist a desired gender recognition might be relevant to discussions of service-provider practices in relation to clients.

In 1990 Judith Butler made a hugely significant contribution to the discussion of the social construction of sex, gender, and sexuality with her book *Gender Trouble*. Arguing, as a philosopher, that “in fact, perhaps ‘sex’ is as culturally constructed as gender; indeed perhaps it was always already gender, with the consequence that the distinction between sex and gender turns out to be no distinction at all” (p. 7), Butler suggests that the categories of gender and sex are discursively produced as cultural norms through reiterative performativity. While Butler’s theory of gender as performative overlaps with West and Zimmerman’s concept of “doing gender,” they differ in the conception of the “self” that *does* gender. West and Zimmerman were writing in a tradition that recognizes some sort of stable, unified “self,” whereas Butler conceives of the self as always unstable and discursively produced (Risman and Davis, 2013).

For Butler, the binaries of sex, gender, and sexuality are produced as natural, coherent identities through performative acts that have no origin. Sex, gender, and sexuality are seen as naturally flowing one from the other: biological sex (female) implies gender (femininity), implies sexuality (attraction to men for women, and vice versa, therefore, heterosexuality). Butler uses the term *heterosexual matrix* to “designate that grid of cultural intelligibility through which bodies, genders, and desires are naturalized” (1990, p. 151).

In Butler’s analysis, these stabilizing concepts of sex, gender, and sexuality produce “identity” and cultural intelligibility. But of course intelligibility for some implies lack of intelligibility for others, and much of Butler’s work focuses on the social dynamics of exclusion, and a recognition that every inclusion, of necessity, creates exclusions. Just as women of colour in the 1990s developed a critique based on their exclusion from the term *woman*, so too, when we are inquiring about those whose sex, gender identity, and/or sexuality falls outside of the realm of culturally intelligible "personhood," must we do a "genealogical critique" of the queer subject by asking:

> For whom is outness a historically available and affordable option? Is there an unmarked class character to the demand for universal "outness"? Who is represented by which use of the term, and who is excluded? For whom does the term present an impossible conflict between racial, ethnic, or religious affiliation and sexual politics? What kinds of policies are enabled by what kinds of usages, and which are backgrounded or erased from view? (Butler, 1993, p. 227)

For Butler (and Foucault), every discourse is based in relations of power that create the possibilities for some human identities, activities, and ways of being, while at the same time limiting, constraining, or making impossible, others. Democracy, for Butler, lies in the recognition of discourse's historical nature, and a willingness to interrogate the exclusions upon which discourse, and identities, are produced.

The ideas articulated here are central to my project. In the world of AHR, the bodies, genders, and sexualities of LGBTQ people are often unintelligible within available discourse. The question becomes how do LGBTQ people disrupt, resist, and subvert these normalizing discourses? What strategies do they deploy or not deploy as they make their way through fertility clinics? And what theories of resistance might be helpful in understanding these negotiations?

Recognition / Resistance / Resignification

I do not assume that LGBTQ people become clients of AHR clinics in order to consciously or intentionally "resist" anything. People go to fertility clinics to get pregnant, to donate or freeze gametes, as intended gamete donors and/or non-biological parents, or to accompany and/or support others. However, in the process, a complex set of interactions takes place—an ontological choreography as Thompson describes it. At play are discourses of fertility and infertility, of family planning and heterosexual reproduction, kinship, femininity and masculinity, parenthood and biomedicine, as well as those of queer and trans identities, and of queer parenting and queer family creation. It is these nuanced and complex discursive negotiations of identity, bodily experience, subjectivity, and “the microscopic processes of power” (Ringrose, 2013, p. 74) that I explore.

Of course this relates to discussions and debates about the concepts of “resistance” and “agency” and about how subjects actively or passively, consciously or unconsciously, resist and/or change the dynamics of power that have an impact on their lives. Raby (2005) offers an overview of theories of resistance, particularly in the context of youth studies, that is useful here. She contrasts modernist approaches that assume a known, rational, pre-discursive, internally coherent, acting subject, with a clear position in relation to domination and a clear source of agency, with poststructuralist approaches that view subject positions as flowing from discourse, as unstable and fragmented, and that perceive power as variegated, rejecting the concepts of grand narratives or “absolute truth” (p. 155). She explores the usefulness and limitations of each of these approaches, concluding that while modernist approaches might do best in informing broad social movements, poststructuralist approaches offer “exciting opportunities for understanding people’s participation in power relations at the most micro level in the deployment, reproduction and transformation of power” (Raby, 2005, p. 168). It is this micro level of power relations that is the focus of this project.

Theoretically, I draw on concepts of *negotiating discourse*, *recognition and intelligibility,* and *resignification.* Because my project is about the ways that LGBTQ bodies and subjectivities both assume and disrupt subject positions in their interactions with AHR systems, I do not assume a straightforward relationship to the concepts of “resistance” or “agency.” The concept of subjects that *negotiate* discourse is central to my framework. Henriques and colleagues (1984) address these concerns about the nature of subjectivity and discourse, questioning

> both a rational, choosing agent *and* an over-determined, subjectified, trapped subject, instead suggesting a new vocabulary to try to understand how subjects *negotiate* discourse, that is, comply and resist through conscious and unconscious psychical processes informed by regimes of power and discursive contradictions. (as cited in Ringrose, 2013, p. 74)

For example, the discourse of queer parenting asserts that “love makes a family,” and at the same time, queer parents are sometimes choosing to engage in very complicated medical procedures (for example lesbian reciprocal IVF) in order to guarantee a “biological” connection to their children. This desire for biological connection disrupts and contradicts the notion that love is all you need. And sometimes discourses are negotiated in ways that have contradictory effects. For example, as Butler points out, the diagnosis of “gender identity disorder,” applied to a person who desires sex reassignment, is demeaning and pathologizing of the ways that gendered lives are lived (1994, p. 5). On the other hand, the diagnosis of such a disorder can be the path to the desired outcome, an institutional requirement in order to access surgeries and hormone treatments. Similarly, a diagnosis of “infertility” implies an inability to get pregnant and in most instances cannot be applied to a queer person visiting a fertility clinic or sperm bank in order to access the services and/or gametes necessary to have a baby. On the other hand, a diagnosis of “infertility” can be helpful in accessing benefits plans and services. These sorts of discursive contradictions are, at least in part, the subject of my inquiry.

What is at stake in the negotiation of discourse is intelligibility, the “terms by which we are recognized as human,” terms that are “socially articulated and changeable, ” but which “produce a differential between the human and the less-than-human” (Butler, 2004, p. 2). For Butler, opportunities for change lie in recognizing the historical and cultural nature of discourse, the ways that norms are established discursively and always contain exclusions. When those outside a norm claim a place within it, the category is put into crisis (Butler, 2004, p. 10). It is the resignification of categories that builds inclusivity and democracy:

> The "failure" of the signifier to produce the unity it appears to name is not the result of an existential void, but the result of that term's incapacity to include the social relations that it provisionally stabilizes through a set of contingent exclusions. This incompleteness will be the result of a specific set of social exclusions that return to haunt the claims of identity defined through negation; these exclusions need to be read and used in the reformulation and expansion of a democratizing reiteration of the term. (Butler, 1993, p. 221)

In an early work (Epstein, 2002), I wrote about the possibilities for resignification through the experiences of butch-identified women who get pregnant, give birth, and mother. I suggested that butch pregnancy and motherhood, by linking a queer masculinity and sexuality to the attachments of the female body, offer possibilities for the reconfiguration of "butch" to include new relations to vulnerability, dependence, and attachment, while at the same time working to deconstruct the dualisms of sexuality/motherhood (since butch is most often seen as a sexualized subject position whereas motherhood is desexualized) thus, at the same time, reconfiguring "motherhood." Finally, I suggested that butch motherhood puts butches in a different relation to the social organization of mothering, perhaps shifting their relation to feminist struggles to provide social supports to those who mother (p. 55).

This is an example of the ways that discursive subject positions are unstable and open to disruption in unexpected ways (Gomez, 1998), through rearticulating or resignifying not new subjectivities or identities, but "those possibilities that already exist within cultural domains designed as culturally 'unintelligible and impossible'" (Butler, 1990, pp. 148-49).

I draw on these concepts of *negotiating discourse*, *recognition and intelligibility*, and *resignification* in my analysis of the narratives of LGBTQ fertility clinic interactions. Which identities, families, biologies, reproductive capacities, and desires are intelligible in a fertility clinic context, and which are not? What assumptions and discourses about kinship, gender, sexuality, reproduction, and biology are negotiated as LGBTQ people make their way through the clinic? What stories are told and not told? What identities, affinities, family configurations, or body parts are revealed/not revealed and embodied/disavowed? What strategies do people deploy in their presentations of self and kinship configurations? What kinds of subject positions and discourses do people occupy in the clinic: client? patient? informed consumer of health care? victim? educator? oddity? normal? natural? ally? enemy? woman? man? transgender? something else? intended father? intended mother? intended parent? “friend”? My interest is in exploring the narratives, identities and discourses people draw on and reconfigure in order to make sense of and manage their AHR experiences. In addition to the concepts I have briefly outlined, I also turn to some recent theorizing from queer theory and trans studies about the negotiation of emerging identities.

For example, Carla Pfeffer’s (2012) work focuses on the dynamics of relationships composed of transgender / transsexual men and cisgender women (similar to at least some of the interview participants in our study). Pfeffer theorizes the negotiation of structure and agency in these couples/families, using the analytic constructs “normative resistance” and “inventive pragmatism.” These concepts are relevant to this project, related to and beyond the particular family configuration she describes. LGBTQ negotiations with AHR systems involve both challenging the norms that are deeply embedded in the institutional cultures of clinics, and strategically deploying these norms (consciously or unconsciously) in order to achieve desired outcomes.

About Terminology

This project is about people who identify as LGBTQ — lesbian, gay, bisexual, trans, and queer. I recognize that the use and meanings of these terms are historical, political, and contested. As Foucault and others (D’Emilio & Freedman, 1988; Katz, 1976) remind us, the concept of “homosexuality” was not a category of personhood until the mid-nineteenth century, and then it was viewed as a form of “gender inversion.” In other words, the concepts of sexuality and gender were intertwined. Gay men were perceived as “feminine” men, and lesbians as “masculine” women.

There is a long, historic, ongoing, and cross-disciplinary discussion about the definitions and relationships between sex, gender, and sexuality. It is now commonly accepted in most LGBTQ circles that gender and sexuality are “distinct, if related, areas of human experience, experiences which are not reducible to one another, nor which can be explained by the other” (Valentine, 2007, 15). Certainly in the educational and activist work I and others do in a broad range of settings, clear distinctions are made between the categories of biological sex, gender identity, gender expression, and sexual orientation. These are commonly defined as separate and distinct characteristics of individuals, one not predictive of the other.

However, in his ethnographic study of the category “transgender,” Valentine (2007) cautions against the acceptance of these categories as “self-evident experiences or as natural explanatory frameworks” (p. 31). He reminds us that they are categories embedded in discourse, and, like all categories, they have complicated histories and politics. The claim that gender and sexuality are distinct might, in fact, be productive of the distinction it aims to describe (p. 31), and the “categories we live by — must live by — have histories, politics and economies and produce effects that can be debilitating for some as they can be liberating for others” (p. 246). His analysis focuses particularly on the ways that poor, racialized, trans women in the United States negotiate terminology, often by not identifying with the term “transgender.” He argues that by assuming we know what is signified by gender and sexuality we can unintentionally erase the complexities of difference, especially considering how the contours of racial or class experiences can shape and reshape what gender and sexuality themselves can mean (p. 18).

However useful and meaningful the distinction between gender and sexuality has come to be, it is crucial to recall the historicized and political nature of all language, and in particular, terms that signify identity categories. I am currently in the final editorial stages of a manual I was contracted to write for a social service agency on working more effectively with LGBTQ-led families. In attempting to finalize the mandatory "glossary of terms" I consulted with three trans friends, each of whom offered different definitions for key terms and each of whom was convinced that different groups of people would be angry with me, depending on how I defined the words. Language is never simple and is always changing.

None of the terms we employ can be viewed as signifying "the real," but rather they "simultaneously carry, enable and restrict meaning" (Valentine, 2007, p. 27). For the purposes of this project, some definition of terms is likely necessary, though for the most part I rely on participant self-identification on the socio-demographic form and in the interview. (See Appendix H for a list of definitions adopted by the research team and appended to project-related publications.) Perhaps the terms most hotly debated, in both academic and activist circles, are "queer" and "trans." For this project I have borrowed Cavanagh's (2010) definition of "trans" or "transgender," however I have removed her inclusion of "butches" and "those who are masculine and female" and "effeminate men" in the definition because not all of these people would identify under the trans umbrella, often now indicated by trans*. Cavanagh defines *trans* or *transgender* as an

> overarching, and necessarily imprecise way to denote those whose gender identities are, in some way, at odds with conventional sex/gender systems and to denote those who have transitioned or who are in transition… including those who are transsexual along with those who are gender-variant…; trans queer

> femmes; and genderqueer, two-spirited and transgenderist people. (Cavanagh, 2010, p. 16)

Of course, as Cavanagh points out, citing Julia Serano (2007), the danger in using umbrella or overarching terms is the disappearance of the range of experiences associated with different locations under the term. Similarly, the term *queer*, another overarching term loosely used to signify those who are not heterosexual, can mask the varied locations and experiences of those who fall under its umbrella. “Queer” is also a complicated term because it has historically been used as a derogatory descriptor of LGBTQ people, and it has been reclaimed or resignified by those to whom it refers. Its history as a term of derision means that people, both within LGBTQ communities and without, are more or less comfortable with its use. Interestingly, in this study, while 48 people identified as “cisgender female,” only 21 identified as “lesbian.” And a total of 18 of the 66 participants identified as queer. While four of these also identified as something else (lesbian, gay, or bisexual), 14 used “queer” as the sole descriptor of their sexual orientation. A striking number (11) also identified as bisexual.

What is most salient here is not so much people’s identifications with regard to gender or sexual orientation, but how these categories are negotiated in the fertility clinic context. The fertility clinic is a highly gendered and sexed environment, where particular forms of gendered and sexed bodies are expected to play very specific biological and social roles in the name of “building family.” And, as Boyd (2006) reminds us: “Bodies that inhabit or enact naturalized states of being remain culturally intelligible, socially valuable, and as a result, gain and retain the privilege of citizenship and its associated rights and protections” (p. 421). So what of the body that is not culturally intelligible? The man with a womb? The woman with sperm? The known sperm donor who is a “father,” but not a “father”? The co-parenting, but not romantically or sexually involved, queer couple or threesome or foursome? These bodies, identities, and interactions will be the subjects of this project.

Methodology

Research Context and Role of the Researcher

The collaborators on this project conceptualized our work as falling under the rubric of community-based research (see Kirby, Greaves, & Reid, 2010; Israel, Schulz, Parker, & Becker, 1998; Access Alliance Multicultural Health and Community Services, 2011). Following in the traditions of participatory and action research, it is a research model that presumes the involvement of "those being researched" in project design, data analysis, and knowledge dissemination. The level of involvement of community members who are not academics varies from project to project (Services to Organizations Community Services Group, 1994), but the premise of community-based research is that projects are developed in response to needs or problems that communities themselves articulate (however these are defined) and that the aim of research is social change. Ginsburg and Rapp (1995) note the tensions inherent in the dual identities of scholar and activist, "in the pull to listen carefully to what people say about their reproductive lives and in our commitment to advocacy and the championing of reproductive rights" (p. 9). For them, the at-least-partial solution to their double identities lies in collaborative methods in which the "concerns and aspirations of the people with whom we work guide both research and action" (p. 10). I think it is fair to say that this project holds at its heart the reproductive concerns and aspirations of LGBTQ people, though of course it is impossible to fully represent or account for the full range of meanings ascribed to these.

I myself was a client of AHR services in 1991, as was Dr. Ross in the early 2000s. Dr. Steele has been both a client of AHR services and an AHR practitioner within her family medicine practice. Since 1997 I have been assisting LGBTQ people interested in becoming parents. In my role as developer and facilitator of LGBTQ family planning courses, through interaction and dialogue with fertility clinic staff, participation in several committees of Assisted Human Reproduction Canada, and facilitation of scores of educational workshops on LGBTQ parenting issues, I have heard hundreds of accounts of people's interactions with fertility clinics. Although the stories were multiply layered and varied in both their descriptions and conclusions, it was clear that people were expressing a lot of frustration, anger, and disappointment about their interactions with AHR systems.

In addition to the studies I mentioned earlier, Drs. Ross and Steele and I had also conducted a SSHRC-funded study of LGBT experience with adoption systems in Ontario in which we surveyed all adoption licensees in Ontario about their policies and practices related to LGBT adoption, and conducted 43 interviews with LGBT people who had been through the adoption process. This project resulted in academic publications (see Ross et al., 2008, 2009a, 2009b), community publications (see www.lgbtqparentingconnection.ca/socialchange) and training workshops around the province for adoption and foster care workers. Collectively we decided that AHR systems were the next frontier. We responded to a special call from CIHR and received a $100,000 research grant to conduct a pilot study of LGBT experience with AHR systems in Ontario.

In line with community-based research principles, we included academic and community partners in the investigator team, and we collaborated with an advisory committee of LGBTQ parenting educators, AHR service providers, and service users. This committee included fertility endocrinologists from most of the larger clinics in Toronto and Ottawa, several AHR counsellors and lab technicians, LGBTQ people who had used donor insemination, IVF, and surrogacy in their routes to parenthood, and several LGBTQ parenting activists. Our intent in involving this range of people was both to expand the inclusivity of our research approach and questions, and to achieve a level of buy-in from those working in the fertility industry. We wanted their support and input in the hope that they would act as conduits for the knowledge dissemination generated by the research. (See Appendix B for a list of advisory committee members.)

In a discussion of narrative inquiry and social change, Riessman (2008) notes that issues of validity can shift in a project that is community-based and community-driven:

> genuinely collaborative projects that serve the participant group's aims at every stage — in study design, methods of data collection and interpretation, and modes of dissemination — can reposition the validity question. In these instances, the research is subject to validation and judgment by participant communities, rather than academic audiences alone (p. 199).

While it is difficult to argue that one's project is "genuinely collaborative" or that participants groups' aims are served "at every stage," the knowledge dissemination projects stemming from this project reflect a commitment to LGBTQ people and communities. These include: a guidebook for LGBTQ people on negotiating interactions with AHR services (Green, Tarasoff, & Epstein, 2012a), a fact sheet for AHR service providers on working with LGBTQ people (Green, Tarasoff, & Epstein (2012b); an interactive theatre production that has been performed both within LGBTQ communities and for AHR service providers, and which is now being transformed into an on-line video education project (with funding from individual fertility clinics); and several academic journal articles and book chapters.[3]

These projects and publications aim to shift the cis and heteronormative framework that LGBTQ people encounter in AHR services and to improve the quality of care they receive. As such, the project is advocacy-based and thus its validity is perhaps best judged not by academic

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[3] James-Abra et al, n.d.; Epstein, 2014; Marvel et al., 2013a, 2013b, forthcoming; Ross et al., 2014; Tarasoff et al., n.d.

audiences, but by LGBTQ communities and by any shifts that take place within AHR services. That said, questions of methodology are significant and I endeavour here to outline the approaches taken in participant recruitment and screening, interviewing, and data analysis.

Participant Recruitment and Screening

Interview participants were recruited between July 2010 and March 2011 through on-line networks (i.e., LGBTQ and health listservs), by mail (flyers) to over 200 service providers and organizations (i.e., fertility clinics, HIV/AIDS service organizations, midwifery practices, etc.), and in person at Pride celebrations across Ontario. Interested individuals contacted the study office by telephone or e-mail, and were subsequently screened by telephone to determine their eligibility. Participants were eligible for an interview based on whether they: were 18 years or older, had used or considered using AHR services since 2007, and lived in and/or used health services in Ontario. The "considered using" was important criteria because we wanted to capture something about the processes by which people made the choice *not to* pursue AHR services, whether for financial or other reasons. Purposeful sampling was used to identify 40 individuals/families from across Ontario who reflected the diversity of experiences with AHR services identified among the individuals screened. Interview participants were also selected based on demographic information (i.e., sexual orientation, gender identity, racial/ethnic identity, income, and geographic location), in an effort to represent the diversity of the LGBTQ population in Ontario. Decisions about who was to be interviewed were not easy. A total of 118 individuals responded to the call, and from these a total of 66 were interviewed. Because prior research on LGBTQ parenting has, for the most part, reflected white, middle-class, urban experience, we were concerned to include a broader range of racialized and class identities in our sample. LGBTQ parenting research has also historically been primarily focused on lesbian identities, with a small but growing body of research on GBQ men as parents, but very little written about GBQ men's involvement in surrogacy arrangements. For these reasons, we were also concerned to prioritize trans and bisexual-identified people, and GBQ men involved in surrogacy, as subjects. In addition, it was critical, as a provincial study, that we conduct interviews with people outside of urban centres, and we also wanted to interview people who had used the range of AHR services available, from very low to very high levels of medical intervention (cycle monitoring, insemination, IVF, surrogacy, gamete freezing, etc.) Thus, our decisions about who to interview became a juggling act of all of these different factors. Ideally, we would have interviewed everybody who expressed interest, but financial constraints made that impossible. In the end, although no accurate statistics are available on LGBTQ AHR service use, my unverifiable assumption is that our numbers likely come close to reflecting the percentages of groupings across the LGBTQ spectrum that actually make use of AHR services: 13 percent of participants identified as cisgender and male, 10.6 percent as trans man/FTM spectrum, and 3.0 percent as trans woman/MTF spectrum (72.7% identifying as cisgender and female). However, in the need to screen for a number of factors (race, class, sex, gender, geography, services used) we lost an opportunity to increase the numbers of people of colour included as participants because we were unable to interview all of the people of colour who expressed interest in participating. Given the lack of focus on LGBTQ racialized identities within LGBTQ parenting research, this is an unfortunate loss. However close to 30 percent of COF participants identified their cultural/racial background as other than white. (For final socio-demographic characteristics of interview participants, see Appendix C.)

Interviews

Between December 2010 and August 2011, we conducted 40 interviews that were between 60 and 90 minutes each with a total of 66 individuals. I conducted only one interview myself, as a training exercise with a research assistant who subsequently, with investigators Lori Ross and Stu Marvel, conducted the rest of the interviews. Interviewers for this project followed a semi-structured guide (see Appendix D), with room to follow up on the stories participants told and to ask questions of curiosity or interest. The goal was to encourage detailed accounts of people's decisions to use, or not use, AHR services, and of their experiences as fertility clinic clients. Prior to the interview, each participant provided written informed consent (see Appendix E) and completed a socio-demographic questionnaire (see Appendix F). The project received ethics approval from the Research Ethics Board of the Centre for Addiction and Mental Health (protocol # 048/2010) and the Office of Research Ethics at York University (certificate # STU 2010-154). (See Appendix G.)

Interviewing in the social sciences, which was once viewed as an act of individual storytelling, is now more widely acknowledged, in line with a move away from structuralist assumptions, to be a co-constructed activity. As Salmon and Riessman put it:

> The audience [or interviewer], whether physically present or not, exerts a crucial influence on what can and cannot be said, how things should be expressed, what can be taken for granted, what needs explaining, and so on. We now recognize that the personal account, in research interviews... is in fact always a co-construction. (2008, p. 78)

Riessman (2008), in her book on narrative methods, stresses the importance of the interviewer's emotional attentiveness and engagement — the willingness to enter into a dialogic relationship with research participants, and to embrace the uncertainty of stepping away from a rigid question-answer format to follow the trails of participant narratives (p. 24). Mainstream social science interviewing, in her view, is about a "facilitating" interviewer asking either discrete open questions and/or closed (fixed response) questions of a vessel-like “respondent” who provides answers. Narrative interviewing, in contrast, is about two *active* participants jointly constructing narrative and meaning, and generating detailed accounts of complex experience (p. 23). Riessman also emphasizes the importance of the researcher’s role conducting the interviews (and ideally the transcription) because the interpretive process begins in conversation.

For this project I am at the disadvantage of being neither the interviewer nor the transcriber. Though I was actively involved in the project’s conception and in the development of the interview guide, I conducted only one interview and did none of the transcribing. What *was* available to me were the electronically taped interviews and the verbatim written transcripts, both of which I have accessed in order to deeply familiarize myself with the content, tone, and texture of each interview.

Thematic Narrative Analysis

My analysis is primarily based on the tapes and transcripts of the Creating Our Families project and the approach I adopt is, loosely speaking, one of narrative analysis. Narrative analysis typically distinguishes itself from other forms of qualitative analysis by its case-based as opposed to cross-case analysis, its emphasis on providing context to written or verbal narratives, and its use of prior theory to guide analysis. Some overarching principles of narrative analysis distinguish it from other methods.

Riessman (2008) outlines what she sees as some key features of narrative analysis, the primary one being the recognition of the historical and social locatedness of the narratives or stories that people produce. When people tell stories, whether in an interview or another situation, the narratives they compose are always strategic, functional, and purposeful (though I would add, not always consciously so). In other words, narratives accomplish things. They are composed or performed for particular audiences at particular times and, like all language, they "draw on taken-for-granted discourses and values circulating in a particular culture. Consequently, narratives don't speak for themselves, offering a window into an 'essential self'" (Riessman, 2008, p. 3), but rather stories become our ways of producing a "self," with a coherent and meaningful history of events and identifications. As Riessman says,

> people construct identities through narrative…who they are and who they are not. People use the narrative form to remember, argue, justify, persuade, engage, entertain and even mislead an audience… Narratives do political work, they provide ways for people to make sense of the past. Storytelling occurs at a historical moment with its circulating discourses and power relations. (2008, p. 8)

Therefore, narrative analysis of data stresses the importance of questions such as: What does this narrative accomplish? How does the storyteller position themselves in the story? What subjectivities and discourses are claimed, utilized, and/or resisted? Stories are a function of all of the circumstances and conditions of their making. Interviews then, are co-created by the interviewer and the participant, or storyteller, under the conditions of that historical moment. One can never assume that the same narrator, under different circumstances, will tell the same story.

For example, consider my own AHR story. I got pregnant with the use of an anonymous sperm bank donor and the services of a fertility clinic. The stories I tell about it vary depending on audience and purpose. If I was being interviewed for a project run by LGBTQ parenting activists with the goal of improving clinical services, I might tell a story of victimization, stressing the inappropriate letter we were sent, the pressure to take drugs, the medicalized environment, and the insensitive and uninformed nurse who kept insisting that "Jews marry Jews" (referring, I think, to the fact that Jews are at higher risk for Tay Sachs Disease) as the reason I should not select a Jewish donor. Or, if I was interested in producing a more "grateful-for-all-in-my-life Buddhist self," I might tell a story stressing the exhilarating nature of the bike ride to the clinic each morning, the fabulous reading I did in the waiting room, the very useful information I obtained from the clinic's cycle monitoring program, and, perhaps most significantly, the positive outcome: pregnancy.

All this is to say that the stories told by participants in this project are not the reflection of a unitary, stable self or an untroubled telling of a factual set of events. Narratives are always articulated from a point of view that is attempts to do or achieve something in relation to its audience. As Joan Scott has so persuasively argued, there is no easy correspondence between life and experience; discourse produces experience as much as experience produces discourse (Scott, 1991). Analysis of interview transcripts, then, is not about revealing the truth of experience, but rather is about how people make meaning of their experience. What do people choose to say and not say? What discourses do they draw on to tell stories? What subjectivities do they occupy and/or reject?

Riessman (2008) suggests that *thematic* narrative analysis, as distinct from other forms of narrative analysis, is a method of interpretation of spoken or written narratives that is *content* focused— it is more about *what* is said, rather than how, to whom, or for what purposes it is said. She contends that thematic narrative analysis holds much in common with, and is often confused with, grounded theory, but that there are important differences between the two methods. They differ in terms of a focus on case-based (narrative) versus cross-case (grounded theory) analysis, and, related to this, on the context provided to stories; and on the role of prior theory in analysis.

Generally speaking, thematic narrative analysis retains a commitment to case-based analysis, while grounded theory pools cases in order to make general statements. Riessman cites Mishler who believes that keeping stories intact honours individual agency and intention and grants individuals “unity and coherence through time, respecting them as subjects with both histories and intentions” (Mishler, 1996 as cited in Riessman, 2008, p. 12). When interview transcripts are coded thematically, bits and pieces of accounts are grouped together according to themes or categories, allowing for cross-case comparison and thematic analysis. However, the subject of the interview becomes separated from the context of their life, and the particularities of a story, the details of how and why the story comes to be told in a particular way, are potentially lost. Direct quotations from interviews, when taken out of context, as Molly Andrews reminds us, “often assume a sense of authenticity which eludes other forms of data… people may appear as if they are ‘speaking for themselves,’ rather than as people whose words were spoken in response to specific questions, and who have little input into how their thoughts are represented in the write-up of the research” (2007, p. 41). Dorothy Smith (1990) also makes a strong case for the value of the “case study” or the particular instance, arguing that any story bears traces of the social relations in which it is embedded. Riessman and Smith would likely concur that any narrative is potentially a way in to a complex network of social processes and dynamics.

While narrative methodologies generally stress the importance of keeping stories intact and retaining both historical and individual context, that is, the details of the “telling,” *how* a narrative is spoken — its audience, structures of speech, and local context (Riessman, 2008, p. 54) — thematic analysis tends to emphasize the “told,” and to favour macro context over local. Rather than attending to time, place, and circumstances of narration, the emphasis is on connections between “the life worlds depicted in personal narratives and larger social structures — power relations, hidden inequalities, and historical contingencies” (Riessman, 2008, p. 76).

Grounded theory eschews prior concepts or theoretical frameworks, aiming instead to "generate inductively a set of stable concepts that can be used to theorize across cases," whereas thematic narrative analysis tends to be guided by prior theory, while at the same time "searching for novel theoretical insights" (Riessman, 2008, p. 74). In other words, grounded theory aims to use qualitative data as the basis of "new" theory, while thematic narrative analysis begins with theoretical concepts in mind, aiming to expand, hone, or further develop them.

While Riessman makes careful distinctions between these analytical approaches, she also acknowledges that they are not mutually exclusive, and that in practice they can be adapted and combined. She encourages innovation and border crossing when it comes to methodologies, urging researchers to interrogate their projects with regards to method, as opposed to "applying" a particular analytic approach (Riessman, 2008, p. 18). She recognizes the usefulness of both theme or category-based analysis and a case-based approach:

> I believe, however, that category-centred models of research (such as inductive thematic coding, grounded theory, ethnography, and other qualitative strategies) can be combined with close analysis of individual cases. Each approach provides a different way of knowing a phenomenon, and each leads to unique insights. (p. 12).

Methodological Approach and Process

I began the data analysis process by listening to the tapes of the COF interviews, taking detailed notes, and writing a summary for each that included emergent themes, points of interest, and things that struck me. Of course these observations and decisions about what is of greater and lesser importance, about what stands out and what recedes, about what is gone back to and what left unnoticed, were the beginnings of my interpretation of these data. In this process, I became particularly interested in the narratives of those whose identities and family configurations lie outside of societal and fertility clinic norms, that is, trans and queer masculine identities and those who are involving known sperm donors in their families, as well as the narrative of a lesbian couple who used reciprocal IVF (i.e., implanted the fertilized egg from one woman in the uterus of her partner).

As I listened to and read the interview transcripts, I also read theory that I thought would assist with this analysis. The approaches and theories I found most relevant are detailed here and in subsequent chapters, including Thompson's "ontological choreography" (2005), Ward's "gender labour" (2010), Pfeffer's notion of "normative resistance and inventive pragmatism" (2012), Ahmed's "diversity work" (2012), Spade's idea of "administrative blockages" (2011), Strathern (1992) and Franklin's work on kinship (1997, 2010/11), Todd (2003) on ethical possibilities in education, and, of course, Butler's contributions to understandings of sex and gender (1990, 2004) and Foucault's understandings of power (1980).

With these theoretical concepts in mind I began to shape the dissertation, choosing to centre chapter 3 on concepts of sex and gender and the experiences of those with trans and queer masculine identities. Chapter 4, on kinship, draws on the experiences of queer women and trans men who are involving known sperm donors, as well as a lesbian couple who did reciprocal IVF. Chapter 5 addresses issues of ethics and pedagogy, with the inclusion of the narrative of one additional COF participant. In total, I draw on 10 of the 40 interviews conducted for the COF study, and 17 of the 66 people interviewed. In chapter 3, I also refer to a non-fiction account written by a butch-identified lesbian about her journey to pregnancy (Jimenez, 2011).

I did not include in my analysis interviews with lesbian/bi/queer female couples who were utilizing AHR services in order to access anonymous donor insemination because, though these narratives are rich, varied, and illuminating, they have been the focus of previous studies (e.g., Luce, 2010; Mamo, 2007, Ross, Steele *et al.*, 2006a, 2006b). Nor did I focus on the interviews with gay and bisexual men who were accessing AHR services as part of surrogacy arrangements. This decision was due partly to the complexities of issues surrounding surrogacy, including legal, policy, and ethical questions which are beyond the focus of this project. Many of these participants were primarily concerned with the implications of the Assisted Human Reproduction Act’s prohibition on paying surrogates, and the resulting grey area of the law, due to lack of regulation, regarding the definition of “legitimate receiptable expenses.” I also continue to be part of a research team that is analyzing these data, and others were more interested in exploring these narratives and the issues they raise.

The approach I take in this project blurs the boundaries between case and theme-based analysis, and, in line with Riessman, recognizes the value of both. My analysis draws on a relatively small number of the COF interviews, including a description of each participant near the beginning of each chapter. In so doing, I aim to present participants as complex and situated subjects, with particular relations to the process of becoming parents and with unique stories about their interactions with AHR services. At the same time, I explore particular themes or issues *across* case, using multiple stories to illustrate or elucidate a theoretical point. However, rather than *pooling* participants’ comments, based on theme-based coding, as would be common in a grounded theory approach, I use excerpts from interviews to both substantiate prior theory and to generate new theoretical insights and ways of thinking. For example, in chapter 3 I draw on Thompson’s conceptualization of objectification to explore LGBTQ experience with AHR services, but then, based on participant narratives, suggest, counterintuitively, that one of the things that might improve LGBTQ experience in fertility clinics is *more* objectification—a separation of body parts and gametes from social identities. I also am careful to recognize those instances where participants themselves provide theoretical insight into their own experience.

Aside from general information about how participants were recruited and when the interviews took place, I do not emphasize the details of the interview context — though the majority of interviews took place in participants' homes, with frequent interruptions from babies and small children. However, I do stress the significance of historical, social, and legal contexts such as: the historical experiences of LGBTQ people being denied the right to have children (in particular, denial of access to AHR services) and having children taken away from them; legal and policy frameworks that are exclusionary, for example, the Canadian semen regulations; the history, culture, and power relations embodied in institutionalized medicine and the experiences of particular groups of people in this context, for example, the impact of trans medical history on subsequent interactions with medical institutions. Participant narratives, rather than being separated from their particularities, are, whenever possible, linked back both to their specific histories and to the larger, macro context.

If narratives accomplish things and storytellers position themselves in particular ways according to circumstances, it is worthwhile to consider the implications of this project's context. Although the COF project was designed to *explore* the experiences of LGBTQ people with AHR services, it was probably apparent, given the researchers' organizational, institutional, and community involvements, that an underlying aim was to *improve* the quality of services. Many participants likely participated because they believed that the telling of their stories would potentially contribute to this goal. While we did hear accounts of positive interactions with individual service providers and with clinics as a whole, for the most part, participants emphasized the experiences that were difficult and the areas they felt required improvement. As Thompson (2005) suggests, fertility and reproductive narratives can also be influenced by outcomes — those who had successfully achieved pregnancy (which included the majority of participants) might tell a different story, or remember or forget certain aspects of a story, depending on when and if they, their partner or co-parent got pregnant. The choices of which stories, and which components of stories, are highlighted here are mine. My hope is that the choices I have made and the theoretical frameworks within which I have placed them prove to be useful in the ongoing work of improving health care to LGBTQ communities.

Chapter 2. Literature Review: Reproductive Technologies, Kinship, and Queer and Trans Families

In this chapter I review feminist scholarship on RTs, delineating earlier writings, which tended to represent a dichotomized view of the technologies as either *good* or *bad*, from later work which recognizes the complexities and contradictions embedded in the development and use of RTS. I look at the impact RTs have had on kinship studies, contributing to a major theoretical shift and a broadening and revitalization of the field, and explore the continuing tensions in both straight and queer kinship studies regarding the meanings and significance of narratives of biology and normalized family structures. Since this project is focused on non-normative queer kinship structures (i.e., trans identities, queer masculinities, known sperm donors), I review the literature related to these and, finally, look at two ethnographic studies of AHR services, one of heterosexual experience in fertility clinics, and the other an ethnography of "lesbian reproduction."

Feminist Scholarship on RTs: A Dichotomized View

Questions related to the possibilities and limitations embodied in reproductive technologies have a long and fiery history of debate. As Sarah Franklin (2010/11) notes, "New Reproductive Technology (NRT) is one of the major themes of post-war twentieth-century feminist scholarship… It is no exaggeration to say that thousands of books and articles have been written by feminists on reproductive technologies—old and new" (p. 1). Early writings in the 1980s tend to fall into one of two categories: those that view the technologies as increasing women's freedom and control of their bodies and reproductive lives, allowing women to fulfill their "natural" role as mothers, and those that view reproductive technologies as ultimately exploitative and "bad" for women, putting control of women's bodies and reproduction in the hands of male science. Dion Farquhar (1996) names these seemingly opposing discourses as "liberal medical discourse" and "fundamentalist discourse," though she argues that ultimately they are complicit, one depending on the other, with both emphasizing the so-called naturalness of the maternal-fetal bond, "treating it as a natural fact and not as a historically and contingently determined relation" (p. 20). These discourses, according to Farquhar, "represent the technologies' capabilities and the practices they have spawned as either salvation or damnation, but only rarely as complex, elusive, and indefinable" (p. 14). As she, and others, point out, neither side of this dichotomized view adequately represents the complexities of the potential impacts of reproductive technologies.

Most early feminist writing on RTs came from radical feminists whose views would fall under Farquhar's fundamentalist category, a view characterized by an anti-technology, anti-patriarchy stance that advocated complete refusal of the technologies. This "just say no" discourse was represented in a number of key volumes (Corea, 1985; Klein, 1989; Raymond, 1993; Rowland, 1992; Scutt, 1990), the first of which was Gena Corea's *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs* (1985). Most of the authors and editors of these texts were also members of FINRRAGE — the Feminist International Network of Resistance to Reproductive and Genetic Engineering, founded in 1986. In Canada, this view was well-illustrated in a 1993 anthology called *Misconceptions*. This volume, exemplifying the stance of many radical feminists at the time, angrily indicts the new technologies. Drawing on analogies with Nazism, fascism, and the horrors of "Frankenstein," the authors warn women of the eugenisist, male-dominated, experimental manipulation of the human body and psyche that is to come. In their view the development of reproductive technologies is a move by masculinist science to control reproduction, and therefore women's bodies. Specific concerns include: low success rates of procedures (i.e., IVF); the experimental nature of the technologies and the subsequent risks to women's bodies and health (for example, the dangers of egg donation); the focus away from the preventable causes of infertility (including environmental factors and sexually transmitted infections, sometimes as a result of sexual abuse); the stress and health risks of multiple births, and overall, the violation of women's integrity and the privatization, industrialization, and medical/technical control of reproduction (Corea, 1993, pp. 18-19).

Embedded in these arguments is a critique of the dangers inherent in a separation of sex from procreation and a portrayal of this separation as a denial of nature itself. Basen (1993), in her piece equating the story of Frankenstein with the development of reproductive technologies, worries about "the monsters we risk becoming when creation becomes a laboratory act, separated from sex and love, this essential human experience that is at once a physical encounter with another person and a loss of control (p. 36). She imagines the worst of infant fantasies and nightmares come true: "My parents aren't my parents. My mother is a virgin. My father is a powerful magician. You can buy babies from a store. I am not the results of anyone else's sexual act" (p. 37), suggesting that children conceived with the assistance of reproductive technologies will be burdened with unbearable confusion. In particular, it is the separation of sex from reproduction that is at the root of this so-called crime against women. As Franklin (2010/11) comments, the feminist writings at this time, with their "NRT = patriarchy" position, "did not always show feminist radicalism, scholarship, or politics at their very best" (p. 2).

However, Franklin also points out that it is misleading to represent the feminist views at the time as having only one version (2010/11, p. 2). Even within FINRRAGE, women were theorizing differently about mothering, about infertility, and about the potential impact of the new technologies. Approaches more sympathetic to the plight of women struggling with infertility began to emerge, as did writings about the potential advantages of reproductive technologies for women (see for example, Pfeffer & Woollett, 1983). A Canadian example of this more toned-down and complicating approach is Overall's 1989 anthology, *The Future of Human Reproduction.*

Franklin's writings on RTs follow the twists and turns of feminist scholarship, and her 1988 review of three major feminist works on reproductive technologies raises issues that later become central to feminist conceptualizations of NRTs. While acknowledging concerns about the impact of NRTs on women's control of their reproductive lives, she is critical of the essentialist, ahistorical stance of much of this work, and instead calls for understandings of lived complexity and of the "shifting and contradictory dimensions of control over reproduction" (Franklin, 2010/11, p. 550). In 1998 she raised the issue she then echoed more than 10 years later in 2011, of what she calls the "signature paradox of feminist debate over new reproductive technologies," (Franklin & Ragone, 1998, p. 3) that is, the question of *choice.* She argues that the concept of individual choice, while having been successfully at the heart of some key feminist struggles (e.g., abortion), is problematic because it flows from a form of liberal humanism that does not acknowledge the context within which choices are made. Media representations of reproductive technologies offer great choice and control, making it difficult to challenge the progressive and benevolent image of technological innovation. Franklin draws on Petchesky's highly influential article (1980) in which she urges that *choice* be viewed in the context of a socio-economic analysis and within a larger framework of reproductive justice:

> The right to choose means very little when women are powerless…women make their own reproductive choices, but they do not make them just as they please; they do not make them under conditions that they themselves create but

> under social conditions and constraints which they, as mere individuals, are powerless to change (p.685).

Franklin also reminds us that increased choice can solve some problems, while creating others. As Rothman (1986) points out in her classic text on amniocentisis, the choice about whether or not to do prenatal screening adds new levels of complexities to the lives of pregnant people:

> The new reproductive technology is offered to us in terms of expanding choices. But it is always true that while new technology opens up some choices, it closes down others. The new choice is often greeted with such fanfare that the silent closing of the door on the old choice goes unheeded. (p. unknown)

Similarly, the choices offered by RTs can add complex dilemmas to the lives of those seeking assistance. Franklin calls it the "disappearing margin between limited choices and *having-no-choice-but-to-choose-one-of-them* (2010/11, p. 3). For those undergoing treatment for infertility the "choice" to discontinue treatment in the context of a medicalized environment that continues to offer options can be agonizing (Kozolanka, 1989). At the same time, viewing "choice" as constructed and contextual can lead to accusations such as those made by early radical feminists that women who choose to make use of IVF technologies are "dupes" of male science. These arguments assume that women are led astray by ideologies that work against their interests and thus become complicit in their own exploitation. Similar debates circulate today in relation to surrogacy — some arguing that women need to be "protected" from exploitative practices, and others that women are capable of making informed choices in relation to their bodies.

The discourse of choice is also central to the liberal discourse on RTs because RTS are seen to offer women increased choices in childbearing. The liberal discourse relies as well on the naturalization of women's bodies and their connection to reproduction. Often found in popular magazines and in the promotion materials of fertility clinics, such discourse extols the wonders of the technologies that can offer those whose infertility is impaired a renewed chance at the "natural" progression of womanhood, from girl to woman to mother. Liberal medical discourses “portray the heroism of pioneering medical teams who achieve ‘miracle’ pregnancies for desperate infertile couples restoring marriages [heterosexual ones, of course] stressed to the breaking point by involuntary childlessness” (Farquhar, 1996, pp. 20-21). These medical and journalistic narratives “offer their audience multiple identifications akin to those of adventure and romance narratives” (Farquhar, 1996, p. 21).

Both of these discourses, the liberal and the fundamentalist, denies the historicity and contructedness of reproduction and parenting and the range of possible experiences of conception and pregnancy, posing instead an ahistorical, unified notion of a female (and male) reproductive and parenting subject. Neither of these discourses dislodge or subvert the assumption of women’s “natural” desire to reproduce within the married heterosexual dyad. As well, both discourses, according to Farquhar, obscure the new technologies’ implications: it is the disruption of the equation of reproduction with male and female bodies, heterosexuality, and the nuclear family that the technologies make possible.

While male reproduction has always been “distributable,” that is, it has been possible to separate the genetic contribution of the male from the social act of parenting, female reproduction has come as a package: genetics, gestation, parenting. Reproductive technologies allow a move away from this essential unitary maternity (the unity between genetic contribution, biological process, and social/legal recognition) to a distributed model of women’s reproductive capacity. The implications of this biological and discursive separation of conjugal sex from reproduction are vast. As Farquhar importantly points out: “by fetishizing the social criteria of ‘the [heterosexual] couple,’ medical discourse invokes the heterosexist standard only to disrupt it by its asexual and third-party donor interventions” (Farquhar, 1996, p. 183). In other words, the use of reproductive technologies to “help” a heterosexual couple to conceive and satisfy their *natural* desires to procreate foregrounds the division of reproduction into the genetic, the biological, and the social and thereby declares its *unnaturalness* (Farquhar, 1996, p. 183).

When reproduction is separated from conjugal sex and the heterosexual married couple, the category is historicized, a myriad of transgressive social and political possibilities are opened up, and kinship and family structures that fall outside this naturalized schema become potentially intelligible. Kinship is potentially transformed.

Reproductive Technologies and the Broadening of Kinship Studies

> I am sick to death of bonding through kinship and "the family," and I long for models of solidarity and human unity and difference rooted in friendship, work, partially shared purposes, intractable collective pain, inescapable mortality, and persistent hope. It is time to theorize an "unfamiliar" unconscious, a different primal scene, where everything does not stem from the dramas of identity and reproduction. Ties through blood — including blood recast in the coin of genes and information — have been bloody enough already. I believe there will be no racial or sexual peace, no livable nature, until we learn to produce humanity through something more and less than kinship. (Haraway as cited in Franklin, 2001, p. 316)

The study of kinship in Euro-American cultures has a complex and contested history. Hicks defines kinship as "a system that organizes and approves particular forms of human relationships" (2011, p. 27.) Freeman (2008), in a recent exploration of possible queer forms of kinship, differentiates *kinship*, "the social policies that recognize some forms of lived relationality — those extending from the heterosexual couple and the parent-child unit — with financial and other benefits," as well as accompanying responsibilities, from *kinship theory:* "the body of knowledge emerging from attempts to abstract the governing principles of relationality — sometimes across cultures — from the practices of intimacy observed in a given culture" (Freeman, 2008, p. 295)

Freeman's definition of *kinship* assumes the heterosexual couple as the foundation upon which kinship is built. And indeed, until the 1950s, kinship was seen as a universal attribute of human societies with the “governing principles of relationality” rooted in the biological facts of gender bimorphism and heterosexual procreation. As Strathern puts it, “having sex, transmitting genes, giving birth: these facts of life were once taken as the basis for those relations between spouses, siblings, parents and children which were, in turn, taken as the basis of kin relations” (1992, p. 5). In traditional kinship studies two kinds of relations are recognized: those based in *blood* (through reproduction) and those based in *affiliation* (through love and/or marriage.) In these configurations, blood relations are viewed as natural, and relations of affiliation as socially constructed, or cultural. As Hicks (2011) points out, the anthropological study of kinship has rested on this pre-given analytical opposition between the biological and the social, between nature and culture (p. 28).

David Schneider’s 1984, *A Critique of the Study of Kinship,* highlighted the two most prominent assumptions of this mode of thinking about kinship. First, that “genealogical relations are the same in every culture” and second, the assumption that “blood is thicker than water.” He argued that these assumptions are shaped by Euro-American (Euro-centric) biologistic understandings of kinship that assume as self-evident the “very aspects of social life that need to be explained” (Franklin, 2001, p. 305), projecting Eurocentric assumptions about universal features of the human condition.

Embedded in early kinship studies are also assumptions about gender that have been soundly addressed by feminist writers, including, early on, MacCormack and Strathern (1980). In 1987, Yanagisako and Colier, extending previous feminist arguments, argued that

> much of what is written about the atoms of kinship… the universality of the family, and the centrality of the mother-child bond is rooted in assumptions about the natural characteristics of women and men and their natural roles in sexual procreation… Above all, we take for granted that they represent two naturally different categories of people and that the natural difference between

> them is the basis for human reproduction and, therefore, kinship. (as cited in Franklin & McKinnon, 2001, p. 4)

Strathern's work (1992) has been hugely influential in challenging both these assumptions about gender and the nature/culture split in kinship studies, arguing, among other things, that there is always an element of *choice* in kin relations, and that kinship is created from negotiated, relational practices that are historical, performative, and constructed. While twentieth-century anthropology would view kinship as the study of the social construction of natural life, Strathern suggests that "what are taken as natural facts are themselves social constructions" (1992, p. 17). She suggests that "the idea of natural kinship has been biologised" (p. 19) and that "what counts as natural has acquired rather specific meanings" (p. 19). To Strathern, the development of reproductive technologies, what she calls the "enterprising up" of the process of conception, potentially makes visible the social constructedness of nature itself and interrogates the pre-analytic supposition of a set of original, natural, "facts of life." Franklin and McKinnon (2001) suggest that the new kinship studies are about "how kinship may be conceived of outside of its ruling sign of biology" (p. 6).

In a sense, Strathern, Franklin, and others (Strathern, 1992; Franklin, 1997; Franklin & Ragone, 1998; Franklin & McKinnon, 2001) have done for "kinship" and "reproduction" what Butler does for "gender." They suggest that what had previously been conceived as universal, timeless, essential, and ahistorical, is in fact embedded in historical social and cultural relations, and thus is unstable and open to reconfiguration. Franklin and McKinnon suggest that kinship, rather than being "grounded in a singular and fixed idea of 'natural' relation… is assembled from a multiplicity of possibly bits and pieces," and is a form of "doing" that is subject to ongoing negotiation and transformation (2000, cited in Butler, 2004, p. 126). Butler concurs that "kinship is itself a kind of doing, a practice that enacts that assemblage of significations as it takes place… characterized loosely as modes of enduring relationship" (Butler, 2004, p. 126). This broadening of what kinship and kinship studies can be about is part of what Franklin and McKinnon would describe as the reconfiguration and revitalization of the field, in effect a "substantial makeover" of the study of kinship (Franklin & McKinnon, 2001, p. 6). Their 2001 volume explores the mechanisms by which "possible lines of relations are brought into being or erased by foregrounding and backgrounding various substantial connections and cultural codings (p. 12).

What is at stake, according to Franklin and Ragone, "are not only traditional definitions of family, disability, parenting, kin connections, and inheritance, but the conventional understandings of nature, life, humanity, morality, and the future" (1998, p. 9). Thompson (2005) acknowledges the impact of this early feminist work in sparking an anthropology of family that "thematized gay parenting, families formed by public, private and transnational adoption, ethnically-based and state-sponsored initiatives to remove children from their parents, and circumstances under which shared blood did and did not confer kinship" (p. 68).

Reproductive technologies, technologies that have the effect of separating conjugal sex from the act of reproduction, of distributing both maternity and paternity, and of differentiating genetic, biological, and social parenthood have been recognized in the field of kinship studies as having had a critical impact on the denaturalizing of biological narratives of the "facts of life." Strathern suggests that "the way that changes in (the field of reproductive medicine) are formulated will affect thinking about kinship. And the way people think about kinship will affect other ideas about relatedness between human beings" (1992, p. 15): "There is little now to be taken for granted" (1992, p. 20).

Butler also argues that kinship is deeply unsettled by practices like donor insemination and international adoption and by the breakdown of the symbolic order of the "mother/father" procreational family. She suggests that developments in the formation of kinship ties can break down boundaries between kinship and community, since kinship ties "may or may not be based on enduring or exclusive sexual relations, and may well consist of ex-lovers, non-lovers, friends, and community members" (2004, p. 127; and of course, see also Weston, 1991). When biological and sexual relations are displaced as the centrally defining aspects of kinship, it allows for "the durable tie to be thought outside of the conjugal frame and thus opens kinship to a set of community ties that are irreducible to family" (Butler, 2004, p. 127). Kinship outside of heterosexual reproduction can become "a set of representational and practical strategies for accommodating all the possible ways one human being's body can be vulnerable and hence dependent upon that of another" (Freeman, 2008, p. 298) or as "the process by which bodies and the potential for physical and emotional attachment are created, transformed, and sustained over time… how our renewal happens on a microsocial level" (Freeman, 2008, p. 298-99). Freeman suggests that reproductive technologies have served to modify kinship terminology so that it now includes such terms as *donor, birth mother*, and *surrogate*, all of which pivot on the distinction between a (physical) progenitor and a (social) parent.

> In fact, RT is a particularly visible and rapidly changing site for the proliferation of new terms that can at least theoretically interlock and detach, expand over time and space in the ways I have described: donors are linked to recipients and genetic offspring; birth mothers can have "blood" grandchildren they may not meet; one can imagine a surrogate mother and the adopting parent(s) constituting a family of sorts (Freeman, 2008, pp. 299-300).

This broadening of understandings of kinship, partially influenced by the increased development of, access to, and use of RTs, significantly shifted feminist scholarship on RTs.

A Shift in Feminist Scholarship: Acknowledging Complexity

The work of Strathern and Franklin was integral to a gradual shift in the 1990s from the moral certainty of early feminist writings on RTs to a “tone of moral ambivalence” (Thompson, 2005, p. 69), a move that began to pay attention to the lived experiences of infertility and to acknowledge the complexity of the social, legal, cultural, and political implications of RTs. Ginsburg and Rapp’s 1995 landmark anthology*, Conceiving the New World Order,* significantly contributed to this shift away from “easy condemnations” (Thompson, 2005, p. 69) and marked a turn toward writings on RTs informed by poststructuralism, feminist science and technology studies, and feminist anthropology. Ginsburg and Rapp recognize technologies as cultural and historical, as neither inherently “good” nor “bad,” but as “cultural objects enmeshed in social, political and economic systems” (1995, p. 5), emphasizing the “uneven and contested nature of the social terrain on which the politics of reproduction are played out” (p. 15). They stress the global nature of RTS and base their book on the concept of stratified reproduction, drawing attention to the ways that RTs are embedded in increasingly complex systems of local, national, and transnational inequalities, at the same time as they open up new and unpredictable possibilities, both locally and globally. They insist on the analytical inclusion of differences based in “generation, ethnicity, race, nationality, class, and, of course, gender” (p. 2), arguing that RTs can have differential impacts in particular contexts. For example, their volume includes explorations of the one-child policy in China, discourses related to the reproductive practices of African American mothers, the control of women’s sexuality in India and Pakistan, and contraceptive testing on women in Brazil. They move discussions on fertility and infertility from a focus on the white, middle-class First World experience of childlessness, to one that includes the multiplicity of ways that RTs can have an impact on people globally.

Work in the 1990s and 2000s that followed Ginsurg and Rapp (1995) continued to focus on the contradictory and unpredictable effects of RTs on the reproductive lies of sexed and gendered people—on the possibilities and constraints that are enabled through the technologies. As Farquhar puts it:

> reproductive technologies function unevenly and ambiguously. Their effects and possible appropriations cannot be specified in advance, out of context, because they vary according to their use and contestions… [they] have the potential to restabilize disrupted or ambiguated identities and relations as well as challenge and transform conventional reproductive assumptions about nature, the body, and social relations (1996, p. 14).

While early radical feminist critiques of RTs constructed “the body” and “nature” as feminine and the physician/provider as masculine and therefore situated the development of RTs as an extension of male power over women’s bodies, later feminist analyses conceptualize “power” in a more Foucauldian-influenced way, as flowing not from a central, sovereign source, but “produced from one moment to the next, at every point, or rather in every relation from one point to another. Power is everywhere; not because it embraces everything, but because it comes from everywhere” (Foucault, 1980, p. 93). As Farquhar points out, if power is seen to operate *productively,* then RTs are “neither unequivocally evil *nor* good (1996, p. 6.) and “bodies can *both* be in control and shape technologies they desire, utilize, adapt or resist at the same time they can be controlled and shaped by them” (p. 4). Reproductive technologies can bolster a pronatalism that sees women’s “role” as primarily procreative; they can also allow women the “freedom” of delayed childbearing, can assist when male or female “fertility” is a problem; and they open up procreative possibilities for singles, LGBTQ people, and others.

Farquhar advocates a “third way,” a discourse of RTs that recognizes the constructedness of RTs as “shifting historical practices,” that are “interactive with individuals and groups’ appropriations and contestations (1996, p. 191). She poses a postmodern analysis that foregrounds the discursive contradictions of RTs by asking

> whether they recuperate compelling traditional but ultimately historically constructed norms of bodily integrity, the nature of maternity, the relation of sex to reproduction, the connection of reproduction with biogenetic continuity, and the stability and simplicity of kinship and social relations. Or, do they interrogate the continued relevance and coherence of these categories? (p. 6)

Of course, in the move to consider both the possibilities and constraints embodied in these technologies, it is a mistake to assume that both the fundamentalist and the liberal discourses do not continue to circulate, and that varied and hybrid versions of pronatalism and/or of women as victims of patriarchal science are not still relevant or visible in current AHR discourse. Franklin (2010/11) reminds us that "the relationship between technology and reproduction can never be separated from wider questions of women's [men's/trans/genderqueer] status and empowerment" (p. 3), and Butler addresses the contradictions that continue to be embedded in the use of RTs:

> Feminists who criticize technologies for effectively replacing the maternal body with a patriarchal apparatus must nevertheless contend with the enhanced autonomy that those technologies have provided for women. Feminists who embrace such technologies for the options they have produced nevertheless must come to terms with the uses to which those technologies can be put, ones that may well involve calculating the perfectibility of the human, sex selection, and racial selection. (2004, p. 11).

RTs themselves are neither "good" nor "evil," and their use will always be mediated by social, legal, political, and cultural relations. A good example of the contradictions and complexities embedded in the use of RTS are persistent tensions regarding the meaning and significance of "biology" in relation to reproduction. These manifest in queer, as well as straight, texts and contexts.

Queer Studies of Kinship — Tensions in Biology and Normalization

Queer studies of kinship (see Freeman, 2008; Hayden, 1995; Lewin, 1993; Luce, 2002; Mamo, 2007; Weston, 1991) contribute to a move away from foundational biological arguments, suggesting instead that kinship can be about dependence, vulnerability, relationality, futurity, sexuality, and, as Weston (1991) so significantly articulated, *choice*. Weston's classic text suggests that gays and lesbians, sometimes in the context of alienation from biological kin, create families of choice that serve to decentre biological ties in favour of "choice" or "love" (or affiliation, in anthropological terms) as defining features of kin relationships. Lewin's (1993) ethnography with lesbian mothers offers a different perspective, concluding that "motherhood," as the defining feature of womanhood, overrides distinctively "lesbian" practices of relatedness.

Hayden uses these two texts as the starting point for a discussion of lesbian kinship, and in particular, "biology," as the "crucial axis around which claims to 'distinctiveness' of gay and lesbian kinship revolve" (Hayden, 1995, p. 41). Drawing on the anthropological work of Schneider (1980) and Strathern (1992), she suggests that lesbians who conceive via donor insemination, while drawing on core symbols of kinship (blood and love), reinscribe these symbols in both predictable, but sometimes distinct or surprising ways (p. 57). In her view, the involvement of the lesbian co-parent in the process of "doing conception," serves to displace biology as the defining feature of parenthood, replacing it with a form of female creativity, a kinetic, generative power that "places the substance (sperm) in motion," challenging "the exclusive correlation that is assumed between heterosexual procreation and the production of kin" (p. 45). Her articulation of the significance of "biology" in LGBTQ parenting, family, and kinship formulations and debates remains key to queer parenting discussions, though of course it is complicated by the complexities I've discussed related to categories of sex, sexuality, and gender. Mamo (2007) uses the term "affinity ties" to describe a "kinship device that lesbians create, in the context of uncertain legal terrain, as they select sperm, assign name and significance to relationships that have no place on traditional kinship charts, and invent new family rituals" (p. 21).

As Franklin points out, the study of kinship has shifted from assumptions about kinship as rooted in "biological facts," "toward an examination of the knowledge practices through which such claims acquired legitimacy, authority and 'obviousness'" (2001, p. 308). She goes on, however, to suggest that the defamiliarization or denaturalization of "biological facts," and the uncertainty about the meaning and significance of biology in relation to kinship, does *not mean* that she is applauding "some new, more flexible, recombinant biology that is less constraining than in the past or is to be welcomed as liberatory" (p. 304). In fact, she argues that "biological facts continue to matter very much to how both 'kinship' and 'gender' are understood, but that they do so in ways that require careful attention, and are not as self-evident as they might appear" (p. 304).

Biology, then, can be conceptualized not as fundamental truth, but as denaturalized and discursive, but also as productive, and as a significant contributing factor in the ways human beings are seen to "relate" to one another. Despite the expansion and revitalization of understandings of kinship, biology continues to matter. The burgeoning fertility industry attests to the fact that biology still matters very much when it comes to reproduction, both in queer and straight worlds. If biology was insignificant to kinship, people would be unwilling to assume heavy financial burdens and to undergo more and more invasive medical procedures in order to create "biological" connections with their children. And, despite the queer adage that love makes a family—the slogan that symbolizes queer rejection of biology as the root of kinship—biology and genetics continue to also figure prominently and in complicated ways in queer reproductive decision making.

For example, biology continues to be central in LGBTQ sperm donor selection practices. Mamo's research (2007) illustrates how, in these decision-making processes, recipients select sperm in ways that privilege "nature" over "culture," relying less "on conceptions of their own nurturing as parents than they do on cultural understandings of heredity and genetics" (p. 206). Sperm is conceived as "possessing an ethnic origin, a health history, and a range of social and personality characteristics… the cultural and physical traits of the donors are rematerialized into the imagined offspring" (p. 206). Pelka (2009) discusses the complexities of sperm donor decisions, pointing out the contradictions between the love-makes-a-family discourse and the great lengths and expense people endure to conceive children to whom they are biologically connected (p. 83). Queer woman in the COF study describe very complex decision making about donor choice; some choose to use brothers as sperm donors, some use the same donor to conceive more than one child, some implant one woman's fertilized egg in the other woman's uterus — all decisions that belie an underlying belief in the significance of biological and/or genetic connection. This tension between nature and culture in queer (and all) kinship mirrors a longstanding debate about the radical nature (or not) of LGBTQ people becoming parents (see, for example, Polikoff, 1987; Lorde, 1987; Copper, 1987; Weston, 1991; Lewin, 1993, 1995; Walters, 2001; Mamo, 2007). How do our families *challenge*, and how do they *recreate*, the conventional model of the heteronormative nuclear family and dominant constructions of gender, sexuality, family, biology, blood, and kinship (Epstein, 2012, p. 382)? It is probably fair to say that there is a consensus that queer family configurations and parenting both draw on *and* disrupt hegemonic norms, and that they are a site within which the relation between nature and culture is continually being worked out, or, as Butler puts it,

> These are (kin) relations that are prone to naturalization and disrupted repeatedly by the impossibility of settling the relation between nature and culture… kinship becomes a site upon which the distinction between nature and culture is figured, worked out, repeatedly naturalized and then disrupted (Butler, 2004, p. 126).

Mamo (2007) recognizes how queer kinship formations can both challenge heternormativity and recreate geneticization narratives (p. 223), and her term "affinity ties" signals queer forms of kinship brought about through "assemblages of meanings of blood, genes, and social and cultural connection…these forms of sociality lie within and between the family one chooses and the family one is given in 'nature'" (p. 231). Queer families continue to be one site within which the nature/culture distinction is continually being worked out.

But queer family configurations are but one example of the complexity of the connections and disconnections that make up twenty-first century kinship. Franklin and McKinnon, in the introduction to their 2001 volume on the new kinship studies, consider "how kinship is created in ways that coexist with, push against, complement, contradict, erase and make explicit divergent means of connection and disconnection" (p.13). They suggest that the lines between kinship and other forms of relationality are fluid:

> On the one hand, friends, villagers, religious associates, "racialized" others, and strangers can be made into kin, while mothers, grandparents, and patrilineal relations can be made into strangers, or "just" friends…
>
> The same substance (blood, genes, eggs, sperm) that is mobilized to create kinship ties in one context, will in different institutional contexts — given different historical, political-economic, and religious forces as well as different individual perspectives — be made to create other kinds of relations, or no relation at all (Franklin & McKinnon, 2001, p. 13).

The provision of sperm is a good example of the fluidity of kinship and the importance of context. It can create a father, a distant uncle, a provider of nothing more than genetic material, or an involved "other."

However, within this context of fluidity, negotiation and choice, Franklin and McKinnon also recognize the restrictions that make process, negotiation and choice "possible for some people in some contexts but not for others" (2001, p. 21), in other words, the continued stratification of kinship and reproduction. Certainly, a significant limitation to much of the existing LGBTQ parenting research is that it draws primarily on the narratives of white, middle-class, urban dwellers. Exceptions include Boggis (2001), who draws attention to issues of class in LGBTQ family formation, and Moore (2011) who recently produced one of the first scholarly works to address the experiences of queer black women raising children.

Franklin and McKinnon cite Weston (2001, p. 168) who, suggesting that kinship is something that congeals, asks: "congealed how, for whose benefit, and from what?" They draw attention to the ways that the breaching of boundaries, "of nations, cultures, species, races, persons, bodies, cells," can also be used "to reestablish and reinforce familiar normative categories" and that "categories such as the natural and human continue to be used to signify what is certain, essential, and given in the nature of things" (Franklin & McKinnon, 2001, p. 21). Two such familiar and normative categories are the *heterosexual nuclear family* and, embedded in this, cultural anxiety about the "need" for a *father*.

Normative Families and the Need for a Dad

> I find myself dreading the summer
> The taunts of the teenage boys
> The stares of expectant neighbours waiting for our husbands to come home
> From work from war from far away from overseas from anywhere
> Just come
> How long can two women together make a barbecue mow the lawn

Raise children
Whose baby is it anyways
I mean who had it, whose is it really
Who is the real mother?
(Lois Fine, "Another Woman's Baby" in Oikawa, Falconer, Elwin, & Dector, 1993, p. 31)

Schneider identified heterosexual intercourse as *the* symbol of American kinship. The overwhelming identification of heterosexual procreation with legitimized kinship has meant that, historically, lesbians and gay men have been excluded from the realm of kinship (Hayden, 1995, p. 43), and, due to their supposed inability to reproduce, to "create," have been portrayed as a significant and dangerous threat to "the family." As Freeman puts it:

> Heterosexual gender norms therefore "make" kin relations, in that they regulate human behaviour toward procreation while appearing to be the result of some primal need to propagate the species. Meanwhile, whatever the connections forged by queer gender performances and other embodied behaviours "make" remains unintelligible as kinship (2008, p. 297).

Butler (2004) suggests that the continued invocation of symbolic, life-giving heterosexuality and marriage are, in fact, a compensatory response to "the historical breakdown of marriage as a hegemonic institution," an attempt to sustain an already irreversibly challenged fantasy (p. 125). Queer families (and others who do not conform to the conventional North American family model) continue to be confronted by, compared to, and assessed in relation to a non-existent heterosexual family norm, a norm that is profoundly embedded in social, cultural, and political institutions.

Sadly, this normative model of the heterosexual nuclear family is a social structure that, in North America, refuses to die in the collective imagination, and continues to be perceived as part of "the nature of things." As I often put it in training sessions, the most significant thing about the construct of the heterosexual nuclear family is that it is deemed "natural," that is, if you put a bunch of human beings out in a field, *this* is the family they will create. Although kinship scholars are recognizing the complexity and contingency of family structures and kinship relations, and despite the fact that the 2011 Canadian census showed a marked decline in the two-parent nuclear family structure,[4] the conventional two-parent heterosexual family model continues to reign supreme when it comes to rhetoric and social policy. As sociologist Judith Stacey (2002) puts it, there is a "dangerous disjuncture between our family rhetoric and policy, on the one hand, and our family and social realities on the other." She argues that legal and social policies "stubbornly deny the complex, pluralist array of contemporary families and kinship, atavistically presuming to serve a singular, 'normal' family structure — the conventional, heterosexual, married-couple, nuclear family (p. 404). Central to the construct (or the fantasy) of the heterosexual nuclear family is deep cultural anxiety about the need for a father.

While feminists, and women in general, have advocated for men to take an equal (or more substantial) role in the raising of children, the manifestation of the Father Involvement movement, and the related, but sometimes differentiated, Father's Rights movement, have been, at best, a mixed blessing. Central to the discourse of "father involvement" are ideas about the necessity of father involvement for "healthy child development," and the citing of a litany of negative outcomes for children who grow up without, or with under-involved, fathers (see for example, Allen & Daly, 2002). Stacey (2002) differentiates feminist calls for men to be more

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[4] The 2011 Canadian census reported increased numbers of one-person, multiple family and "other" households, whereas the number of households composed of couples with children declined. "Other" households include those living with roommates or other relatives. *Canadian household in 2011: Type and growth*. Catalogue no. 98-312-X2011003.http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_2-eng.cfm Accessed March 28, 2014

involved in childrearing, from what she calls “reactionary moves to reify genetic paternity or stereotypical masculinity as crucial to the welfare of children and the nation alike” (p. 402). She cites research that refutes the belief that “the mere presence of a father in a family confers significant benefits on his children” (pp. 402-403) and suggests, as have others (see, for example, Silverstein & Auerbach, 1999), that “it is the quality, commitment, and character of parents, rather than their gender, that truly matter” (p. 403).

Fiona Kelly (2011), in her analysis of Canadian family law in relation to the lesbian family, analyzes how current legal reforms essentially create a framework for lesbian families that mimics the patriarchal, heterosexual, nuclear two-parent family, and that does not allow for recognition of a significant, but non-parental, relationship between children and, for example, known sperm donors. She describes how a backlash to “non-normative” family practices, bolstered by an increasingly powerful fathers’ rights movement, the emergence of a neo-conservative political agenda, and an unprecedented adherence to gender-neutral formal equality in family law, fathers (regardless of the quality of their actual involvement in children’s lives) have emerged as critical to both the preservation of “the family” and children’s best interests (p. 29-30). Citing legal cases in both Canada and other jurisdictions, she portrays a legal landscape that views fathers as “good news,” with courts remaining “resolutely resistant to excluding a known donor from a lesbian family if it means the child will not have a ‘father’” (p. 37).

Non-Normative Identities and Family Structures

The literature on AHR services in relation to trans people is virtually non-existent, though some personal accounts are beginning to emerge (Beattie, 2008; Ware, 2009). Ryan (2009) conducted a small study on the lives of trans parents, but her study did not include interactions with AHR services. Pyne (2010) recently conducted a literature review related to cisnormative assumptions and discrimination in the lives of trans parents, as well as a research project based on focus groups with trans parents (Pyne, 2012). His literature review details a history of devastating discrimination. For example, Brown and Rounsley

> report that until the 1980s, therapists at gender identity clinics suggested that parents undergoing a gender transition should disappear forever from their children's lives to avoid harming them, even telling the children that they had died in some cases (Brown & Rounsley, 1996, p. 187).

While some research and writing on trans parenting is shifting from a deficit model to an exploration of the strengths and possible benefits of having trans parents (see, for example, Brown & Rounsley, 1996; Hines, 2006; Garner, 2004; Canfield-Lenfest, 2008; Feakins, 2009), for the most part trans people continue to be excluded from the social agenda of mainstream research and to suffer from both informational and institutional erasure (Namaste, 2000; Bauer et al., 2009). For a discussion and references related to trans exclusion from AHR services, see pp.8-9 of this dissertation.

Regarding queer masculinity and parenting, Moraga (1997) and Jimenez (2011) each write about their experiences as butch-identified lesbians who chose to get pregnant. Epstein (2004) suggests that butch pregnancy can reconfigure the subjectivities of both "butch" and "mother," and Walks (2012), in her doctoral dissertation, addresses the reproductive desires, choices, and experiences of butch lesbians, transmen, and genderqueer individuals in British Columbia, using an analytic framework of feminine pregnancy as "cultural fetish."

Accounts and analysis of lesbian decision making and negotiations with known sperm donors are found in Mamo (2007), as well as in short chapters in Agigian (2004) and Sullivan (2004), though neither address these negotiations in the context of fertility clinics. The vulnerability of the non-biological parent(s) has long been recognized and articulated in writings on lesbian parenting. An early lesbian anthology, in a piece about the stressors facing lesbian families, explores the dimensions of this subject position:

> No matter how strong her presence and involvement in the family… it is she who disappears, it is she who is disenfranchised—by the school, by both families of origin, by the outside world, sometimes (even more painfully) by the children or by friends in the lesbian network who do not see her as a parent nor understand the unique pressures of her position in the family. (Crawford, 1987, p. 205)

The growing literature about lesbian co-mothering (Abelson, Epstein, & Ross, 2013; Crawford, 1987; Gabb, 2005; Hequembourg & Farrell, 1999; Muzio, 1999; Sullivan, 2004; Tasker & Golombok, 1998; Wilson, 2000), cites the complexities of this subject position, the inequalities in recognition and intelligibility in relation to family, friends, and communities, and the vulnerabilities and fears attached to parenting a child one has no biological connection to, often with little or no legal recognition or protection. This literature also addresses the strategies deployed by lesbian couples to attempt to equalize or “tie in” the “other” mother (Sullivan, 2004). These include choosing a donor with physical characteristics similar to the non-birth parent; arranging for the non-birth parent to be the at-home parent; inducing lactation in the non-birth parent; and naming practices (for example, including the surname of the non-birth parent in the child’s surname, or having the child call both women names that reflect equal parental obligations (Hayden, 1995, p. 50).

The non-biological lesbian parent, like the known sperm donor, is a kinship configuration that defies traditional kinship language. Brown and Perlesz, in a study conducted in Australia, found 45 different terms used to describe the non-birthing lesbian parent (2007, p. 277); they draw attention to the processes by which language both reflects and constructs experience (Benkov, 1994, p. 172), and can be used to both convey and/or conceal relationships.

Goldberg and Brushwood-Rose (2010) interrogate discourses of biology in queer reproduction in a compelling collection of narratives written from a diversity of locations within the queer women/known sperm donor configuration. Questions of "biology" are central as well to two volumes that specifically address "non-biological parenting": Aizley (2006) and Miller (2010). Both of these authors raise the significance and power of "resemblance talk," the ways that people both within and outside of queer families look for, comment upon, and make meaning from who looks like whom in the queer family. Luce's 2010 study, based on ethnographic work in British Columbia, provides the most detailed account to date of Canadian lesbian reproductive practices, and Mamo (2004) provides the American equivalent. Epstein (2009) includes narrative and analytical pieces on a wide range of identities and themes, including a piece on trans fertility clinic experience (Ware, 2009), the contradictory ways that disourses of biology are deployed in lesbian reproductive practices (Pelka, 2009) and an interview with three men who donated sperm to lesbians (Epstein, 2009, p. 104).

Nordqvist (2011) analyzes the dynamics of sperm donation, suggesting that the separation of the donor — their ejaculation process and bodily fluids— from the recipients of the sperm is achieved in the clinical setting through the anonymity framework but also through the medical procedures of analyzing, washing, freezing, and thawing sperm, and through the medical staff's practices. Referring to Thompson's concept of "agency through objectification," by which "technology enhances subjectivity when body parts, which are objectified through the medical gaze in treatment, come to 'stand in' for the woman in a synecdochal relation" (Nordqvist, 2011, p. 1662), she argues that, in the case of donor insemination, exactly the opposite occurs. The donor and his gametes are intentionally *disconnected,* thereby reducing the anxiety, awkwardness, and risk often associated with donor insemination by the recipients of donated gametes. The synecdochal relationship is severed in this case, “transforming the donor and the sperm from being person-like to being thing-like” (p. 1667). Of course, she also suggests, this separation is never complete, and the “tensions around sexuality, intimacy and personal life embedded in the process of retrieving sperm” are managed, but never fully resolved.

Ethnographies of RTS: Thompson and Mamo

Thompson’s 2005 ethnographic study of fertility clinics and Mamo’s 2007 ethnography of lesbian reproductive practices are two examples of work that takes as its starting point the contradictory, historical, and unstable nature of the practices associated with RTs. Charis Thompson’s (2005) ethnography of fertility clinics is the result of field work she carried out in fertility clinics between 1988 and 2004. Based on hours of observation of all facets of clinic life, she explores the complex ways that reproductive technologies can both bolster existing norms and transform social relations. Through a concept she names “ontological choreography” she explores the “dynamic coordination of the technical, scientific, kinship, gender, emotional, legal, political, and financial aspects of ART clinics… a deftly balanced coming together of things that are generally considered parts of different ontological orders (part of nature, part of the self, part of society)” (Thompson, 2005, p. 8). Within this broad framework, Thompson uses the concepts of *normalization, naturalization, and agency through objectification* to explore the economic, social, political, and legal complexities of gender and kinship that are negotiated in the daily practices of fertility clinics.

Briefly, her discussion of normalization explores the processes that govern who is the “appropriate” user of AHR services. The norms of the clinic require that patients ideally present themselves as heterosexual couples who can pay for services, who act with civility, are compliant with diagnostic and treatment protocols — including accepting that the primary focus is the woman's body, that "natural" cycles give way to "disciplined" cycles, and that length (and cost) of treatment, justified by statistics, becomes open-ended. Thompson uses *naturalization* to refer to the ways that kinship and procreative intent are strategically naturalized by patients. For example, a heterosexual egg donor IVF cycle (a woman carries a pregnancy conceived from a donated egg and her male partner's sperm) begets different kin relations than a gestational surrogacy (a woman carries a pregnancy that is conceived from a donated egg — or the egg of the intended mother — and the male partner's sperm). In the first case "motherhood" is determined based on gestation or biology; in the second case "motherhood" is determined based on either intention and social/legal grounds, or based on genetics. In each case, the kin relationships are naturalized.

Thompson also recognizes fertility clinics as dynamic cultural sites, wherein women and men are constantly negotiating their own subjectivities in the face of objectification — of bodies, reproductive parts, and substances. Countering a tradition, particularly visible in early radical feminist RT critiques, that views objectification as antithetical to subjectivity and agency, she suggests that objectification of one's body can be part of a strategy to achieve a goal (pregnancy), that it may be possible "to discern potential gains for the long-range self within different dimensions of objectification" (2005, p. 202).

One of her most compelling chapters explores the dynamics of masculinity in the clinic. Because a diagnosis of male factor infertility can threaten a masculinity that is ordinarily defined through virility and paternity, men have to negotiate, achieve, and protect their compromised male identity, sometimes through displays of hypermasculinity (pride in the numbers of one's sperm count; jokes about the porn used to produce the sample; performance of the "supported and committed husband," etc.). When a heterosexual couple enters the AHR environment the focus is most often on the woman’s body, which begins to stand in for the couple. Thompson’s look at masculinity, then, is an attempt to understand a fuller range of the gender dynamics at play.

Thompson’s ethnography explores the intersections of lives, subjectivities, and technologies, and is especially concerned to point out moments, within the often mundane daily operations of a clinic, of unexpected agencies and political configurations. She portrays the interactions in the clinic as a complex mutual choreography based in sameness and novelty, routine and innovation, and reminds us that “change is not sudden, forward looking, always irreversible, but instead is iterative, multidirectional, patchy, frequently conservative, and often the result of unintended consequences” (Thompson, 2005, p. 14). She is more interested in understanding complexity than in producing narratives of unidirectional or static relationships and negotiations.

Thompson’s work, however, focuses almost exclusively on heterosexual experience. Nordqvist (2008) argues, in fact, that virtually all feminist studies of reproductive technologies reproduce a heterosexual imaginary of procreation, effectively rendering lesbian reproduction inconceivable. By contrast, Laura Mamo’s ethnography, *Queering Reproduction* (2007), is probably the most elaborated analysis to date of North American *queer* women’s reproduction. Based on in-depth interviews with 36 women who identified as lesbian, gay, bisexual, or queer, as well as key interviews with practitioners in the AHR field, Mamo provides a rich analysis of the dynamics of lesbian conception and family making. Beginning by tracing the historic shift from a self-help, do-it-yourself, turkey-baster model of lesbian conception, to a much greater reliance on the services offered by “Fertility Inc.,” she follows the journey of lesbian baby making from initial preparation, to decision making regarding sperm donors, to the varied trajectories women find themselves on, from low-tech at-home insemination to high-tech intervention at a clinic. She explores the concept of kinship in lesbian parenthood, introducing the notion of "affinity ties," "a kinship device that lesbians create, in the context of uncertain legal terrain, as they select sperm, assign name and significance to relationships that have no place on traditional kinship charts, and invent new family rituals" (Mamo, 2007, p. 21).

Throughout this work, Mamo grapples with the contradictions I noted earlier (see p. 61 of this dissertation), and that have been addressed by many writers (Polikoff, 1987; Lorde, 1987; Copper, 1987; Weston, 1991; Lewin, 1993, 1995; Walters, 2001) on LGBTQ parenting: the tensions between resistance and accommodation; agency and objectification; conformity and transgression. Mamo describes the doubled nature of lesbian reproductive practices like this:

> The ways that lesbian insemination denaturalizes the assumed link between heterosexuality and parenthood casts doubt on hegemonic foundational assumptions, and opens new possibilities for gender, sexual expression, intimacy and family forms… at the same time as reflecting and reinforcing regulatory ideals of how to make sense of reproduction, biology, family, and social life, etc. (Mamo, 2007, p. 22).

The participants in our study reflected an enormous range of such sex/gender and family configurations. Many lesbian couples included known sperm donors in their family lives with a range of levels of involvement; trans men partnered with other trans men went to clinics to get pregnant via donor sperm; cisgendered women partnered with trans women went to clinics to get pregnant via sperm from their partners; trans men and women accessed (or attempted to access) clinic services to freeze gametes; single people across the LGBTQ spectrum also used AHR services to build families.

While many of these family configurations significantly destabilize the highly sexed and gendered model of the conventional heterosexual nuclear family, on the other hand, their narratives of donor selection reveal sometimes surprisingly traditionalist conceptions of the desirability of various traits (i.e., race, intelligence, health, physical characteristics, and emotional make-up) and how these are "carried" in gametes — many couples chose anonymous sperm donors as a way to protect the integrity of the two-parent family. As Mamo reiterates, queer reproductive practices are embedded in contradictory discourses and practices and have the "power to extend kinship… but also the potential to re-entrench the nuclear family by tightening the two-parent hold on normative family tropes" (p. 92). Queer reproductive practices both rely on and destabilize foundational social and cultural assumptions.

Mamo ends by summarizing some of the issues and dilemmas raised by the constantly developing, shifting, and vastly complex terrain of reproductive biomedicine. She raises questions about the future:

> Who will be deemed legitimate users of these technologies? Will these users continue, transform, or reduce current forms of stratified reproduction? Will old variants of social control persist? Through what means will new variants of social control emerge and in what places? Similarly the question is not whether possibilities will emerge for social transformations, but for whom? Gaining an "accurate" version of social relations requires interrogations of material cultures in practice. Such interrogations must explore the forms of particular forms of negotiations and trajectories employed to achieve pregnancy; the ways that kinship is enforced and altered symbolically and materially; the ways that sex, gender and sexuality are reworked or maintained; and the ways that reproduction is raced, classed, and gendered. (Mamo, 2007, p. 243)

Mamo gestures here toward my own work, Although her ethnographic project includes interviews with lesbians who chose to use known sperm donors, her analysis is specifically of "lesbian" reproduction, and focuses particularly on the reproductive journeys of lesbian couples. She does not explore the dynamics and negotiations that take place when other queer and trans-identified people bring their biologies, sexualities, gender identities, family configurations, and reproductive desires to the clinic. This dissertation therefore carries on where Mamo left off, contributing to feminist, queer, and trans scholarship on kinship, reproductive technologies, and institutional pedagogy by exploring a broader range of identities and kinship configurations in interactions with AHR services, and by raising important questions regarding ethics and education.

Chapter 3: Space Invaders

The ontological choreography (Thompson, 2005) of the fertility clinic is a process by which things come together to facilitate a (heterosexual, cisgender) patient's flow through the clinic. This flow is supported by gender work (Ward, 2010), that is, the work the clinic does to repair and bolster damaged heterosexual cisgender identities, as well as the various processes by which patients, their body parts, and gametes are objectified in the service of a long-range self — the self that wants to be pregnant. These processes of objectification can enhance agency when there is no metaphysical rupture to a patient's sense of personhood or subjectivity. But when LGBTQ people (who are like space invaders) (Ahmed, p. 38, citing Puwar, 2004) enter the site of the fertility clinic the flow of the patient through the clinic is disrupted by the stickiness of the heterosexual matrix's assumptions (Butler, 1990)— disrupted by the inability of administrative procedures and clinic staff to disentangled the assumptive links made between body parts, gametes, bodies, gender, sex, sexual orientation, sexual practice, and family configuration. As a result, the gender work typically carried out in clinic settings works against LGBTQ clients' subjectivities, and processes of objectification that might otherwise enhance flow through the clinic serve to further the misrecognition and lack of intelligibility of LGBTQ clients. Ruptures to personhood also occur as a result of administrative misclassification (Spade, 2011). LGBTQ clients sometimes adopt strategies to negotiate their lack of recognition in the clinic which, while adopted in service of the goals of a long-term self, can also create ruptures to personhood. These processes by which the flow of queer and trans bodies through the clinic get stopped by ruptures to personhood or subjectivity, are what Ahmed (2012) refers to as "blockages," suggesting that the experience of blockages is also a source of knowledge. If, as Thompson suggests (2005, p. 201), ethicality is evaluated by the presence or lack of violations to personhood, this chapter points to the failure of clinics to recognize the personhood of those whose subjectivities lie outside of normative cisgender heterosexuality and to the need for clinics to examine their ethical practices in relation to LGBTQ clients.

Ontological Choreography

Thompson characterizes the goings on in fertility clinics as an “ontological choreography,” by which she means the

> dynamic coordination of the technical, scientific, kinship, gender, emotional, legal, political and financial aspects of ART clinics. What might appear to be an undifferentiated hybrid mess is actually a deftly balanced coming together of things that are generally considered parts of different ontological orders (part of nature, part of the self, part of society). These elements have to be coordinated in highly staged ways so as to get on with the task at hand: producing parents, children, and everything that is needed for their recognition as such (2005, p. 8).

She argues that this kind of choreography between different kinds of things is particularly striking in fertility clinics because of the overlap and intertwining of matters of technology with matters that are intensely personal and political. In the fertility clinic bodies, body parts, parents, families, instruments, equipment, doctors, nurses, technicians, drugs, medical procedures, bureaucratic procedures, counsellors, etc. are all part of a dance of “ontologically heterogeneous things and people in the service of a long-range self” (p. 204). The long-range self is the self that wants to get pregnant (or have a partner or co-parent get pregnant) and become a parent. The process of making one’s way through a fertility clinic involves ontological heterogeneity:

> A patient who is going through a cycle of treatment is sometimes a person who juggles her work schedule to be at the clinic, sometimes a generic patient who sits in the waiting room, sometimes ovaries and follicles that appear on an ultrasound screen, sometimes an anesthetized body that lies on a surgical table, sometimes a patient with blocked tubes, and so on. The genius of the setting — its techniques — allows these ontological variations to be realized, to multiply and to be coordinated. By passing through them, a patient embodies new options for her long-term self (p. 182).

For Thompson it is this choreography that enhances the "flow" of the patient through the clinic. She uses language of mobility and movement to characterize the patient's passage through the clinic, referring to "trails of activity" that can either peter out if there is no successful pregnancy, or can lead back to and transform the long-range subject if there is a successful cycle culminating in a pregnancy (p. 203).

Gender Work

> Of course it is not obvious how to interact with queer bodies and genders, just as we do not naturally or automatically know how to engage normative genders and their accoutrement. Successfully recognizing and affirming the gender of the other — whether the normative or transgressive other — involves a significant amount of training, study and practice — which, like all forms of work, can be very pleasurable, theatrical, and dynamic, or it can be tedious, failure-ridden, and compulsory." (Ward, 2010, p. 237)

Judith Butler shifted theorizing about sex and gender by suggesting that the categories of both sex and gender are discursively produced as cultural norms through reiterative performativity. She explores the "fundamental unnaturalness" of cultural configurations of sex and gender (1990, p. 149) arguing that sex, gender identity, and sexuality are constituted through a repetition of acts with no origin, robbing compulsory heterosexuality of its claims to naturalness and originality (p. 124).

Butler uses the term *heterosexual matrix* to "designate that grid of cultural intelligibility through which bodies, genders, and desires are naturalized" (1990, p. 151). The heterosexual matrix is:

> a hegemonic discursive/epistemic model of gender intelligibility that assumes that for bodies to cohere and make sense there must be a stable sex expressed through a stable gender (masculine expresses male, feminine expresses female) that is oppositionally and hierarchically defined through the compulsory practice of heterosexuality. (p. 151)

In Butler's conception of the heterosexual matrix, biological sex, gender identity, and sexual practice are produced through reiterative performativity as normalized and naturalized components of identity, with the appearance of being linked to and stabilized by the other. Biological sex is expressed by gender, both of which are expressed in heterosexual practice.

In the fertility clinic the heterosexual matrix is the norm, and the assumptions embedded in this configuration become so naturalized that they go unnoticed. Bodily secretions, bodily productions, and body parts are routinely linked to sexed and gendered bodies, normative sexual orientations, and predictable (heterosexual) sexual practices. Gendered body parts (ovaries, uterus, testicles, penis) produce gendered gametes (sperm, eggs), and are tied to sexed bodies (male / female) with binary gender identities (man / woman), normative gender expression (femininity / masculinity), normative sexual orientation (heterosexual), and normative sexual practice (heterosexual intercourse — which is called "sex"). The desire to have children in a heterosexual context is taken to be "natural" (Thompson, 2005, p. 92) as are a set of feelings, attitudes, and behaviours associated with womanhood and manhood, femininity and masculinity, and maternity and paternity.

Using a less philosophical and more sociological framework, West and Zimmerman argue that gender is a "routine accomplishment embedded in everyday interaction" (1987, p.125), suggesting that gender is something we *do* more than something we *are.* Like Butler, they critique the taken for grantedness of binary models of sex and gender that are perceived as both natural and essential: "We do not think, 'Most persons with penises are men, but some may not be', or 'Most persons who dress as men have penises.' Rather, we take it for granted that sex and sex category are congruent — that knowing the latter, we can deduce the rest" (p. 132). Citing Garfinkel, whose case study of Agnes has become infamous, they emphasize the ways that a binary view of sex, gender, and sexuality (Butler's heterosexual matrix) has a profound moral status, "in that we include ourselves and others in it as 'essentially, originally, in the first place, always have been, always will be, once and for all, in the final analysis, either 'male' or 'female'" (Garfinkel, 1967 as cited in West & Zimmerman, 1987, p. 133). They suggest that gender is accomplished through the production of "required identificatory displays" (p. 127) that include appropriate gendered markers (clothes, hair, behaviour), and through deeply embedded social practices that create seemingly natural and essential differences between girls and boys and woman and men (p.137). The sex segregation of North American public bathrooms is a good example of how gender is accomplished through the assumption of innate, essential, and biological differences between the sexes, even though both "are somewhat similar in the question of waste products and their elimination" (Goffman 1977 as cited in West & Zimmerman, p. 137). Cavanagh (2010) provides an in-depth analysis of the gendered nature of public bathrooms and how they demarcate masculinity and femininity and condition ideas of gender and sexuality.

Despite the differences in the theoretical underpinnings of their work, both Butler and West and Zimmerman offer analyses that interrogate the essential character of gender (and sex and sexuality), an essentialism typically rooted in biology and what is deemed "natural." They understand gender as performative and as produced/accomplished through interaction and institutional practices, though by no means voluntary and always constrained by what Foucault would call "regimes of power." Gender is deeply rooted in the regime of hegemonic heterosexuality and stabilized by material, discursive, and institutional practices that recognize, in a myriad of ways, some expressions of gender and sexuality as intelligible, and others as not. Human beings are brought into gendered subjectivities through parodic repetition of acts that have no original. As such, there is a vulnerability to the categories of gender, sex, and sexuality—a fragility and instability within identity categories. Though we live in a world that sees gender as fixed, certain, and real, in fact, gender identity is fragile, contingent, and often in need of shoring up.

In her article, “Gender Labour: Transmen, Femmes, and Collective Work of Transgression,” Ward also addresses this process by which gendered subjectivities are brought into being, made coherent, and stabilized. She too assumes the inherent instability of gender categories and suggests that gendered subjectivities are constituted in an individual not only by their own performativities and interactions in the world, but also, at least partially, by the labour of others, that “gender itself is a form of labour” (2010, p. 236). Countering what she sees as queer theory’s emphasis on the individual and on individual forms of gender transgression and “defiant self-making,” for example, the “gender outlaw,” she suggests that queer/trans relationality, or what Halberstam (2005) describes as “a relation between people, within a community, or within intimate bonds” (p. 49), has been too little explored. She brings attention to “how queerness takes form in and through the more micro-sphere of relationality — particularly the feminized realms of caring and witnessing which literally nurture gender subjectivities into possibility” (p. 238).

Ward’s particular interest is the labour that femme-identified women do to assist in the production of gender coherence in their trans (FTM) partners. However, she suggests that *all* genders demand work, and therefore that all people both give and require gender labour (p. 239). This is true not only for queer or trans gender identities, but “also for understanding the collective work that produces masculinities and femininities in all of their various iterations (p. 239). Butler, West and Zimmerman, and Ward concur that gender is produced through a proliferation of individual, interactive, and institutional practices. Both the repetition and potential failure of repetition of parodic gender performance elucidate the fragility and contingency of *all* gendered subjectivities.

If we take this analysis of the production or achievement of gendered subjectivities back to the fertility clinic, one might assume at first glance that the highly gendered environment of the clinic, an environment steeped in the assumptions of normative cisgender heterosexuality and traditional masculinity and femininity, might, as Thompson puts it, “provide a counterexample to the idea of gender as ontologically and experientially performative” (2005, p. 118). While the gendered responses to infertility one finds in a fertility clinic might appear to bolster structuralist or essentialist notions of gender (woman as relational and nurturing; man as positional and individualistic), Thompson argues that it is precisely within the gendered dynamics in clinic settings *that the performativity and fragility of gender become apparent.* Drawing on Butler’s early notions of gender performativity (Butler, 1990) as well as her subsequent clarifications regarding the non-existence of a “voluntaristic subject who exists quite apart from the regulatory norms which she/he opposes” (Butler, 1993, p. 15), Thompson acknowledges that the gender dynamics in clinics are framed by the deeply constraining historicity of “heterosexual hegemony” (Butler, 1993, 15). However, she goes on to suggest that the performativity of gender is as easily apparent in normative heterosexuality as it is in the queer forms of gender addressed by queer writers and theory and, in fact, that “identities that seek to achieve authentic heteronormativity by parody, enforcement, or substitution of one kind or another show the constructedness of gender just as strongly [as those that are disruptive of heternormativity]” (Thompson, 2005, p. 119).

In particular, the parodic performances of masculinity she observed in fertility clinics reinforce the notion of gender as performative and highlight the “constructedness, situatedness, multiplicity, and fragility” of all gender identities (Thompson, 2005, p. 138). As she puts it, “In fertility clinics, the ontology of gender is also destabilized by the possibility of failure to perform hegemonic gender by those who precisely in this site must try harder than ever to perform and norm gender” (p. 118). In the context of fertility clinics, *all* gender identities are fragile, contingent, and performative and their coherence is enabled by what Ward calls “gender labour” — routinized forms of care work that serve to bolster or repair an individual’s gendered subjectivity (Ward, 2010, p. 237).

In a fertility clinic the most prevalent gender work bolsters and repairs damaged or failed cisgender heterosexuality. The practices of clinicians, as well as those of patients themselves, work to stabilize normative discourses of heterosexual reproduction — to naturalize what is often an “unnatural” flow of body parts, gametes, sex, gender, sexuality, and sexual practice to produce something resembling the natural trope of heterosexual reproduction and to repair and stabilize the normative masculinities and femininities that go along with it.

Of course, men and women are not synonymous in the clinic. While both women and men struggling with infertility are faced with challenges to normative gender identities, the meanings they attach to their experience typically differ, or at least are assumed to differ. When a heterosexual couple is being treated for infertility the goal becomes a successful pregnancy in the woman’s body; her body parts become the focus of treatment. Men, whether they are dealing with “male factor” infertility or are simply providing sperm to impregnate their female partners, are reduced to an ejaculatory role (Thompson, 2005, p. 121) (though they are also expected to be committed and supportive partners.) The man’s main job in the fertility clinic is to supply sperm, in an act that is linked to sexuality, manliness, virility, and his ability to impregnate a woman. He is the one sent off to the donation room, cup in hand, the one who must use the provided pornography to produce a sexual response and a sperm sample, and the one who must then return the sample to a clinic staff member, *while everyone knows where he's been.* For his female partner, getting pregnant in a clinic setting is *not* tied to her sexuality (though Jimenez, 2011 makes the connection between sex and the vaginal ultrasound). And for women, the stigma and loss of childlessness is often much more significant than the stigma of not being able to get pregnant. In other words, Thompson found that, among cisgender heterosexual couples accessing fertility clinics, the woman's identity often seemed more attached to becoming a mother whereas the man's identity was involved in fathering a child. For women, childlessness is often linked to a questioning of or challenge to their womanliness (you can't really call yourself a woman until you are a mother); for men, the inability to father a child challenges their virility, sexual prowess, and manliness. (If you can't father a child, then you are not really a man) (Thompson, 2005, p. 136).

Because the gender work that goes on in the clinic is about repairing threatened masculinities and femininities, it relies on and evokes hyper-gendered subjects who are striving to meet the benchmarks of normative gender—the ability of women to become mothers and men's ability to sire children and be worthy fathers. In fact, Thompson suggests that exaggerated versions of the hyper-conventional gender roles typical of the normative nuclear family are deployed in the fertility clinic just at the moment when reproductive technologies and the "novel sociotechnical settings" they produce, threaten to show up the fragility of these categories. The newness and innovation of the technologies are normalized by, as Thompson puts it, interpreting them as "new examples of old things" (p. 141). Innovative forms of reproduction and family building are made less scary by linking them back to conventional gender roles and familial configurations that are familiar. I return to this point later, arguing that, in fact, the innovative possibilities contained in RTs, if separated from the need to normalize, actually lay the ground work for new forms of "gender work" and "objectification" that could serve to recognize a broader range of genders, sexualities, and family/kinship configurations.

Thompson's work on gender in the clinic focuses particularly on clinic practices that work to bolster or repair damaged masculinity. She suggests that for men, gender identity in the clinic has two components: being "good patients," that is, supported and committed husbands and, therefore, worthy fathers; and virility—the ability to produce sperm and sire a child. The "good" male patient in the fertility clinic is expected to get along with his partner and accompany her to appointments, do a bit of male bonding with the physician, and comply with recommended treatment procedures.

Virility and sperm production are recognized in a variety of ways. Men are boastful and self-congratulatory and are congratulated by others on their "very good numbers" when their sperm count results are revealed. Women patients applaud when a man visits the donation room and returns with his sample in record time. Stereotypical heterosexual male fantasy is normalized and even mandated in the sperm donation room — women endorse and support their partner's use of pornography to produce sperm, and, as Thompson puts it, "displaying ease with the world of commercial male fantasy was a sign of knowledge of and compliance with the treatment culture and regime" (p. 128). As one COF participant remarks: "this is one particular instance where porn has a place in society that's completely… defensible." Any critique of the content of normative heterosexual porn is displaced by its usefulness in restoring damaged masculinity.

The practices and discourses brought into play in fertility clinics to bolster masculinity in need of repair fall under the rubric of what Ward (2010) calls “gender work” or “gender labour.” The gender labour inscribed in the fertility clinics’ practices is designed to bolster and repair damaged heterosexual, cisgender identities, and families. One can imagine then, that the bodies, gender identities, and sexualities of queer and trans people might be unintelligible within a system so steeped in repairing and sustaining cisgender heterosexuality. When these forms of gender work meet LGBTQ people and identities there is a clash of assumptions and a resulting deep misrecognition. LGBTQ people arrive at the doors of fertility clinics having experienced a history of denial of parenthood, contested relations with medical institutions, and sometimes living with difficult tensions regarding transitioning and parenthood. At a moment when appropriate and specific “gender labour” might be in order, they often encounter practices and assumptions that serve to alienate and undermine social identities. Ward’s concept of gender work, and Thompson’s ethnographic work on gender repair in the clinic prove useful, both in identifying the faulty gender work that LGBTQ people confront, as well as to reflect on what gender work outside the assumptions of the heterosexual matrix might look like.

Objectification

Central to her articulation of the ontological choreography of the clinic is Thompson’s analysis of the process by which patients negotiate their own subjectivities in the face of *objectification* — of their bodies, reproductive parts, and bodily substances. Countering a convention, particularly visible in early radical feminist critiques of RTs, that views objectification as *always* antithetical to subjectivity and agency, and the fertility clinic patient as either helpless and saved by the technologies or victimized by them, she suggests that, in the fertility clinic context, objectification of one’s body can be part of a strategy to achieve a goal (pregnancy) and that it may be possible "to discern potential gains for the long-range self within different dimensions of objectification" (p. 202)—dimensions that involve being neither helpless nor a victim. She calls this process "agency through objectification," suggesting that women patients (whose bodies are typically the primary focus of AHR medicine), at various points in their treatment, manage their own objectification, and "willingly accept the role of being the object of the medical gaze and in fact actively participate in it" (p. 191). Patient agency is not only compatible with objectification but sometimes *requires* periods of objectification (p. 185).

Processes of Objectification

Thompson details the following forms of objectification that structure a patient's agency in her passage through the clinic. She does not suggest that "agency through objectification" is straight-forwardly simple, always present, or never threatened, but that in the flow through the clinic each patient features under many ontological descriptions during the course of treatment. Patients exercise agency in their active participation in a number of different kinds of objectification (p. 199).

UnBlack-Boxing of the Body. Typically, patients of fertility clinics have spent at least a year trying to get pregnant and in this time have amassed a huge amount of information about what may previously have been only vague understandings of their reproductive bodies. Often those seeking assistance from fertility clinics already possess detailed, scientific information about eggs, ovaries, hormones, temperatures, sperm counts, cervical mucous, luteal phases, etc. (p. 193). Thompson calls this accumulation of knowledge "anticipatory socionaturalization," or the "unblack-boxing" of the body. The medicine practised in clinics "allows new access to these processes and body parts. It renders the body parts visible and manipulable and subjects them to all sorts of tests so that they yield facts on which to base diagnoses and treatment" (p. 193). The process of objectification by which a woman “takes an active interest in her own presentation as an object of study” (p. 191), can work to the benefit of her long-term self for whom pregnancy is the goal.

Generic Bureaucratization. The ontological choreography that manages the flow of bodies through the clinic means that at times an individual is highly bureaucratically generic, at other times highly specific and uniquely individualized, and at still other times somewhere in between. In the waiting room, Thompson suggests, the patient is objectified in a nonspecific, bureaucratic sense as they are assimilated into the normal routine of the clinic. Only generic properties are relevant at this stage: the patient needs to arrive on time, come when she’s [sic] called or fetched, and behave within the normal parameters for the clinic. This process of generic bureaucratization can potentially threaten a patient’s individuality but it also enhances her flow through the clinic.

Body Parts. The patient is rendered into multiple body parts many times during a treatment cycle. During the pelvic exam or the vaginal ultrasound the patient’s body parts are rendered visible (unblack-boxed). The character of the conversation between the patient and the physician changes so that the patient’s internal reproductive organs become the focus of attention, the goal being to draw out and classify some of the contents of the Pandora’s box that is now the patient’s body. The cold metal speculum (often loathed) (p. 193) becomes part of the trail along which the patient’s parts are brought into contact with possible treatment. This change is choreographed through coordinated positioning of gloved medical staff, as well as by swabbing the patient and inserting the speculum. These mundane steps render the body and the instruments compatible and are at the heart of objectification (Thompson, 2005, p. 193).

During the pelvic exam, the patient herself moves in and out of various forms of objectification, subjectivity, and social identity. She begins as someone who carries the usual identificational weight in the waiting room, moves to a place where it is appropriate to undress and wear a gown, becomes an object of study with instruments, and ends as someone who gets dressed and interacts face-to-face. Multiple social roles are temporarily irrelevant while she is being examined. The temporary loss of social identity makes it possible to “offer up” her body parts for intervention (p. 199).

Gametes and Embryos in the Lab. The andrology and embryology laboratories are where semen is washed, spun, and separated before inseminations, and where embryos are created. In the lab gametes and embryos become “temporarily independent genetic emissaries,” in a space that enables human gametes and embryos to exist outside patients’ bodies. The lab maintains an ontology of connectedness between patients and body parts during the time when the two are separated, and the gametes and embryos are tied back into trails leading to the woman, structuring the use of lab equipment, lab procedures, and the behaviour of lab technicians (Thompson, 2005, pp. 197-98).

These forms of objectification, generic bureaucratization, and the separation of body parts and gametes from patients’ bodies, when not at odds with a patient’s subjectivity, can enable flow through the clinic. Thompson links these processes to questions of medical ethics.

Ethics: Personhood and Technology

Without denying the subjugating and disciplining effects of many technologies, including RTs, Thompson raises questions about why sometimes “personhood and technology stand in opposition and why sometimes they stand as partners” (p. 201). She argues that whether or not a patient experiences processes of objectification as enhancing or depriving of agency can depend on whether or not the practices of objectification maintain a synecdochal relationship to the patient's long-term self. In other words, objectification enhances agency when it is possible to discern potential gains for the long-range self; it deprives agency when the synechdocal relation fails and the "objectification stands in opposition to aspects of personhood that are cared about deeply and guarded carefully" (Thompson, 2005, p. 201).

For example, the ultrasound (or pelvic exam) consists of a trail of instruments and technicians and an objectified patient. The procedure provides the patient (and medical staff) with important and often new information about her body and/or body parts, information that connects back to her long-term goal of achieving pregnancy.

> As long as these trails of actants-in-the-setting flow back to the patient, the synecdochal relation between the body parts and the patient is maintained. This material maintenance of synecdoche ensures that the objectification of the patient that consists in the education and itinerizing of her body parts is not opposed to her subjectivity (Thompson, 2005, p. 195).

Thompson finds that patients' descriptions of procedures in the clinic are often contradictory, and change over time, seemingly based on whether or not a rupture with the long-range self has occurred. A patient might talk about feeling alienated, dehumanized, or objectified if a metaphysical rupture has occurred between the long-range self and the entities that are deployed in objectifying the patient (administrative and medical procedures, instruments, language, etc.) Whether or not a patient experiences such a rupture often depends on the outcomes of treatment. The simplest example is the difference between an experience of objectification that leads to a successful cycle and pregnancy, versus one whose outcome is a failed cycle.

> When the patient talks about a failed treatment cycle that she doesn't assimilate to any ongoing treatment, she often expresses herself as having been alienated or dehumanized. In this case, the trails of activity have petered out without reclaiming the long-range subject, leaving a dualistic metaphysics in which objectification and agency are oppositional. When speaking about a successful cycle, the trails of activity have led back to and transformed the long-range

> subject, and the heterogeneous or hybrid ontology of the treatment zone becomes irrelevant. (Thompson, 2005, p. 203)

If the patient is unable to stay identified with the goals of the long-range self, she experiences a rupture between the forms of objectification and the long-term self.

Thompson suggests that questions of medical ethics might be informed by a framework that evaluates ethicality based on the conditions for the maintenance of synecdoche. Medical procedures, technologies, and practices might be evaluated based on whether patients experience them as strategies in service of the long-term self and thus as enhancing of agency, or whether they are in some way rupturing of personhood or subjectivity, and therefore depriving of agency (p. 201).

For LGBTQ people, processes of objectification in the fertility clinic are often unsuccessful because of the ways that LGBTQ identities, body parts, bodies, genders, sexualities, etc., are misrecognized and unintelligible within the clinic setting. This can result in ruptures to “aspects of personhood that are cared about deeply and guarded carefully” (Thompson, 2005, p. 201), and therefore to experiences of alienation, anger, and frustration. Objectification is often unsuccessful because the assumptions of the heterosexual matrix are so deeply engrained and so difficult to disentangle that, for example, it is very unlikely that the body parts of a trans man undergoing an ultrasound or pelvic exam can be disentangled or viewed separately from other aspects of identity, or that a trans woman who is providing sperm can be separated from her gametes.

Enter Space Invaders

> To find that you are fundamentally unintelligible (indeed, that the laws of culture and of language find you to be an impossibility) is to find that you have not yet achieved access to the human, to find yourself speaking only and always *as if you were* human, but with the sense that you are not, to find that your

> language is hollow, that no recognition is forthcoming because the norms by which recognition takes place are not in your favor. (Butler, 2004, p. 30)

For Butler (and Foucault), every discourse is based in relations of power that create the possibilities for some human identities, activities, and ways of being, while simultaneously limiting, constraining, or making others impossible. The stabilizing concepts of sex, gender, and sexuality produce “identity” and cultural intelligibility. But of course intelligibility for some implies lack of intelligibility for others, and much of Butler’s work focuses on the social dynamics of exclusion, and the recognition that every inclusion, of necessity, creates exclusions.

When queer and trans people enter the world of AHR, they enter a world that builds inclusion based on normative cisgender heterosexuality. In the framework of a fertility clinic, a butch-identified masculine woman who is trying to get pregnant, a female-bodied person who has no desire to get pregnant, a man with ovaries, a uterus, and the capacity to get pregnant, or a woman with a penis and sperm are unintelligible. These bodies are not the bodies that are expected. And, as Sara Ahmed (2012) puts it, when those who are not expected arrive, they are “noticed (p. 35)In her book based on interviews with “diversity” workers, Ahmed explores the work involved in the institutionalization of whiteness and the ways that “institutional spaces are shaped by the proximity of some bodies and not others” (p. 35). For people of colour, entering a space that is shaped by whiteness can feel like “walking into a sea of whiteness” (p. 35). As Sam, a black trans man, puts it:

> A lot of times at the clinic we’ve been the only ones of African descent, the only black people. I mean, very rare you would see someone else and you’re like Oh… wow!... right? …like we never really saw ourselves reflected there. And then they have these walls of photos, you know, tons of babies. And *occasionally* there’s...black children. But out of three hundred photos, there might be two. And so, it’s like who...how are...how could we end up here, you know?

Ahmed borrows Nirmal Puwar’s (2004) expression, “space invaders” to evoke the experience of entering a space in which you are not expected. Puwar describes how “white bodies become somatic norms within spaces and how nonwhite bodies can feel ‘out of place’ within those spaces” (Puwar as cited in Ahmed, 2012, p. 38). Ahmed says that

> If we think of institutional norms as somatic, then we can show how by assuming a body, institutions can generate an idea of appropriate conduct without making this idea explicit…If institutional whiteness describes an institutional habit, then whiteness itself recedes into the background. (2012, p. 38)

Without presuming simplistic symmetry between race and other categories of identity, I would argue that in a fertility clinic, cisgender heterosexualilty, whiteness, and economic privilege are the “habit.” Those who fall outside these categories are “space invaders,” walking into a sea of white, privileged, cisgender heterosexuality. When one enters a space in which one is not expected, simply walking into the room can be discomfiting (Ahmed, 2012, p. 40). Sam goes on to describe the discomfort he experiences when he enters a space that, on several fronts, does not expect him. In addition to feeling out of place racially, he is aware of the ways that he and his partner do not fit the clinic’s expectations of financial privilege, and of how their trans identities cause a blockage in the system:

> Sam: At [clinic name] the assumption is that you have...$2000 for your insemination that at any time of the month you could just get out. And if you don’t have it in cash, you would have credit of course…because of course *everybody* has credit cards and everybody is in good standing and everybody has money. And then, the clinic is set up is to provide creature comforts for busy executives who have to take time out of their day to come here. So they have a computer for you to check your mail…CP24 on TV with the stock exchange, the fancy stress-reliever chair, the $3000 aquarium tank so that you can be soothed and relaxed…and you know...some actually really expensive prints on the wall…Well, clearly they’re not hurting for change at all, because this is big bucks here. So people who don’t work or people like me who are part-time, and then people like us who don’t have, um, what do they call it...disposable income...that’s not who the clinic is for. So they were always *surprised* when we didn’t have money in just like [snaps *fingers*] this for things. Like we were somehow not…prepared.
>
> Well, they flagged our application...they called back our family doctor…to question the referral— because why would two men be in need of insemination?

He is left uncertain about the root of the discomfort he senses in the medical staff he encounters:

> Sometimes it’s hard to distinguish when people treat you differently. I always go through the list— Hmm...is it because I’m black? Is it the trans thing? Is it because I’m fat? Is it because I got my head shaved? You know? And so, I think there’s a couple of times we had some strange interactions with some of the technicians, ultrasound people. And I was like “What is that about?”

These feelings of discomfort and uncertainty are common to those who enter an institution but are outside its norms.

Institutional Plumbers: Identifying Blockages

Ahmed (2012) identifies the metaphor of “coming up against a brick wall” as a recurring theme among those who, like Sam, enter an institution but are outside its norms. It is only in coming up against these norms that the norms become visible.

> When you don’t quite inhabit the norms, or you aim to transform them, you notice them as you come up against them. The wall is what we come up against: the sedimentation of history into a barrier that is solid and tangible in the present, a barrier to change as well as to the mobility of some, a barrier that remains invisible to those who can flow into the spaces created by institutions. (Ahmed, 2012, p. 175)

Like Thompson, Ahmed uses language of mobility and flow to describe processes by which some people “flow” through institutions, while others are seen to block, get in the way of, or go against the flow. “The flow, in other words, is a fantasy that is protected by blocking the exposure of the blockage (Ahmed, 2012, p. 186).” Countering the emphasis in much current social theory on fluidity, mobility, and liquidity, Ahmed’s explains that her work on diversity has taught her about *solidity*, “about how what appears as mobile and changing *can hold its shape*,” and about the intransigence of institutions and the difficulty of social transformation (p. 186). Diversity workers, she suggests, are “institutional plumbers,” who point out blockages—the places where things are “stopped.” In so doing, they produce significant knowledge about the blockages, restrictions, and stoppages within institutional worlds (p. 181). The practical work of coming up against blockages, of noticing where “the flow” becomes stuck or solidified, the places where one cannot reside, allows “the wall” to become apparent. To those who do not come up against it, the wall does not appear — the institution is lived and experienced as being open, committed, and diverse (p. 174). Things might appear as fluid if you are going the way things are flowing. But when you’re not going that way, you experience a flow as solidity, as what you come up against. In turn, those who are not going the way things flow are experienced as obstructing the flow (p. 187).

Administrative Blockages

Dean Spade’s book *Normal Life* (2011) examines in detail how modes of administrative governance can work to make trans people’s lives administratively impossible. He argues that administrative policies and practices work to shape the world “into categories that, ultimately, are taken for granted by most and thus appear ahistorical and apolitical. Indeed, many such categorizations are assumed as basic truths” (Spade, 2011, p. 141). Like Ahmed (2012), he suggests that it is only when one hits a blockage, a place where one does not fit, that the construction of the categories themselves becomes apparent.

> These decisions about what constitutes a proper data element/matter of classification and what does not rarely appear as controversial political decisions because people who find the commonly evoked societal norms used in classification familiar and comfortable tend to take these classification systems as neutral givens in their lives. *We are used to filling out forms with certain questions.* We rarely question how we came to be asked for those particular pieces of information and not others except in moments when we personally have a hard time figuring out which box to check off. Because certain classifications become common and standard, there is often an implied shared understanding that certain things, like gender, are just necessary information for administering government programs (Spade, 2011, p. 141).

He identifies three general administrative realms that interact to create complex difficulties for trans people, with far-reaching, long-term ramifications (p. 144). These are: gender classification on I.D. documentation, sex-segregated spaces (for example, bathrooms, vaginal ultrasound rooms, andrology labs), and access to gender-conforming health care.

Below I draw on queer and trans people's narratives about their experiences in fertility clinics, as well as on a nonfictional account of a butch-identified woman's journey to pregnancy (Jimenez, 2011), to explore how practices of "gender work," "objectification," and "administrative classification" (Spade, 2011), which might enhance flow through the clinic when situated within the assumptions of the heterosexual matrix, can work against the subjectivities of LGBTQ clients and serve to further their misrecognition and lack of intelligibility. The flow of LGBTQ people through the fertility clinic is "stopped" or "blocked" by violations of personhood that occur as a result of staff's inability to disentangle the assumptions of the heterosexual matrix.[5]

I use the concept of "flow through the clinic" to narrate a typical experience in a fertility clinic, using the following order of events: waiting room, pelvic exam/ultrasound, meeting with the doctor, andrology lab. Of course there are elements left out, and this is not always the sequence of things, there can be back and forth between these settings and procedures, and people use fertility clinics for other procedures, such as freezing gametes, IVF, etc. My aim is to create a sense of how "flow through the clinic," for LGBTQ clients, is often blocked both by deep misrecognition on the part of clinic staff, and also sometimes by the range of strategies LGBTQ people themselves adopt in order to negotiate their way through the clinic. I define blockages as those places where a sense of personhood, identity or subjectivity is violated or ruptured in some way.

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[5] As I mentioned earlier, the strategies LGBTQ clients adopt in negotiating their lack of recognition in the clinic, while adopted in service of the goals of a long-term self, can also create ruptures to personhood.

The People

Sam and Rob

Sam and Rob both identify as black, trans men. Because Sam has decided to get pregnant, he has not been taking testosterone for several years. This has slowed down his transition process, a fact he is not happy about, and he has found it somewhat challenging that his partner has been able to continue his transition process uninterrupted. Sam and Rob went to a fertility clinic because Sam's periods were irregular and they wanted assistance with diagnosis, cycle monitoring, and insemination. Sam was diagnosed with polycystic ovarian syndrome and prescribed a drug, Metformin, which also is used to assist with diabetes. He was also given a hysterosalpingogram (a procedure that involves injecting dye into the fallopian tubes to check that they are clear), and prescribed Clomid and injectable fertility drugs.

Both Sam and Rob were unhappy about the many drugs Sam was put on, and expressed dissatisfaction with the process by which consent was solicited. They also expressed concern that Rob was subjected to blood testing (the clinic did not realize he was not providing sperm), which included a mandatory HIV test that was carried out with no offer of counselling, or even awareness that the test was being done. Overall, they found their experiences in the clinic to be stressful and traumatic. They felt that Rob was ignored when they realized he wasn't part of the process, and he eventually stopped coming to appointments.

Sam got pregnant, then miscarried, and they were offered little or no support in this process. The clinic lost the results of the miscarriage which might have given them some information about why it happened. After the first pregnancy they decided to do home insemination with a known donor, but were afraid to tell the doctor at the clinic about this decision, leaving him to think that they were using sperm from a bank at home. They were told to "have sex today, have sex tomorrow, have sex the day after, and then come back and see us."

Stacey and Nina

Stacey and Nina identify as a white, lesbian couple. Stacey is a trans woman and Nina is her cisgender female partner. They have decided that they want to conceive using Stacey's sperm and Nina's egg. Nina will get pregnant and carry the child. She is subjected to many tests for infertility, though she has no reason to think she will have difficult conceiving. The story they tell of their fertility clinic experience is one of profound misrecognition and lack of intelligibility. They are interpellated into the clinic as "a straight couple with male factor infertility." Stacey feels that her transsexuality is misunderstood, is distressed by the clinic staff's (mis)use of pronouns, and has an awkward and "bizarre" experience in the andrology lab when she is sent to collect sperm. They refer to her sperm as "the boys," and to Nina as a "good girl" when she ovulates. Nina's view of herself does not match the "hyper-feminine patient of a fertility clinic." Overall, they are both left unhappy about the experience in the clinic, though differently so.

Dan

Dan is a white, trans man, partnered with another trans man who is not present for the interview. Having children is something he has always looked forward to, expected and planned for. He has not yet achieved pregnancy and is still actively involved in the process. He has recently changed doctors because he found that the first doctor did not listen well and did not answer his questions. Because he is determined to get pregnant, he is grateful for access to the clinic and prepared to put up with whatever name, pronoun, or gender they wish to confer on him. He is using a known sperm donor who he is presenting to the clinic as his sexual partner, which causes a lot of anxiety, fear, and worry. Because Dan is appreciative that he can use the donor of his choice, he tolerates the doctor he does not like for longer than he is ultimately comfortable with. His "real-life" partner's name is taken off his medical chart, which includes only his name and the name of his donor (who is presenting at the clinic as his sexual partner), The so-called sexual partner signs forms that assign decision-making rights about what happens with existing embryos in the case of Dan’s death.

Andrea

Andrea is a white trans woman who would like to freeze sperm before her gender transition. She is not sure if she is already too far along in the process to successfully do this, and is also stalled because she has been found to be a carrier of CMV, and is required to pay an additional $2,000 to have her sperm stored separately. She has so far not chosen to do this, and is conflicted about her desire to transition versus her desire to have a child in the future. She is handed a form that asks her to identify herself as “married, single, or gay.” The pornography she is given to assist with sperm donation is all about women’s bodies (which does not work for her) and the close friend accompanying her for support is ignored by health care providers, who insist on asking Andrea about her (non-existent) spouse and what she wants to do with her gametes in case something happens to her.

Jimenez

Although Jimenez (2011) was not a COF participant, her account of her journey to pregnancy is valuable to include in this discussion. She is a butch-identified Chicana woman, partnered with a white woman whose two children, born in a prior heterosexual relationship, they are parenting together. Her memoir documents her process of trying to conceive, including many attempts at locating a man, known to her and her partner, who will act as a sperm donor, as well as her two years as a patient in a fertility clinic, undergoing cycle monitoring and insemination.

Generic Bureaucratization: The Waiting Room

Thompson (2005), in her analysis of objectification processes in the fertility clinic, suggests that generic bureaucratization is one mechanism by which fertility patients make their way through the clinic. Only generic properties are relevant at this stage: the patient needs to arrive on time, come when she's [sic] called or fetched, and behave within the normal parameters for the clinic.

It seems simple — arrive on time, come when you're called, and behave normally. Typically, you arrive at the clinic, introduce yourself to the person at the reception desk, and are handed a form to fill out. You take your place in the waiting room, fill out the form, and you are called by your name for your visit with the doctor or other clinic staff. However, what if the form you are handed makes a series of assumptions that exclude you and your family? What if the name you give them at reception is not the one they call you by when you are summoned? What does it mean to behave "normally" in the face of these potential ruptures to your sense of your own personhood?

Almost every participant in the COF study spoke about the forms they were asked to fill out at the clinic. Forms are important, as I reiterate in workshop after workshop, echoing Spade (2011). Often they are the first thing you are handed when you enter an institutional setting. If you do not fit on the form you are asked to fill out, it can create anxiety, fear, and mistrust and can speak volumes to issues of inclusion/exclusion. It can make you wonder if the clinic staff have ever met someone like you before; if you are the person they expected to come through the door; or if they even have an idea that people like you exist. If you don't fit on the form, it is as if, on some level, you and your particular family configuration do not exist as a possibility.

The forms in a fertility clinic typically ask about the "female partner" and the "male partner" and assume, in their format and questions, the heterosexual couple as the unit of treatment (though the focus quickly becomes the woman's body), and heterosexual intercourse as the preferred mode of conception. Andrea, a trans woman interested in freezing sperm before her transition, describes showing up for an appointment at a fertility clinic and being handed a form:

> Finally, once I'd explained my situation… they gave me forms to fill out. And the first question on the form was "Are you married, single, or gay?" And I'm like, "I don't really know how to answer that question."…I was really alienated by the fact that the forms don't seem to have been updated since 1980. And I said to him "Do you understand that it's not appropriate to ask, in 2008 or 2009 or whatever it was, "if you're married, single, or gay. Those are not three independent categories!"

Married, single, or gay — where to start? The question assumes "married" or "single" are the only options when it comes to relationship status: either you are married or you are single, (and undoubtedly the assumption is that if you are single you wish you were married). The form excludes those who are with a partner but *not* married, those who have one or more partners and are not married to any of them, those who are married *and* have other partners as well, or those who live in other sorts of kinship or familial arrangements. "Gay" as a separate category implies that gay people are neither married nor single; perhaps they exist outside of recognized relationship all together.

In her account of her and her partner's foray into the clinic, Jimenez (2011) describes the forms they are asked to fill out, and the questions they are asked as part of the intake process. The process starts with Hilary (her partner) having been sent a male questionnaire — a questionnaire sent to men who are suffering from what, in fertility clinic lingo, is known as male factor infertility, that is, as the name implies, the male is contributing to the couple's infertility. In the questionnaire Hilary is asked, among other things, about the frequency of her ejaculation. And the doctor, in an in-person, face-to-face interview, asks Jimenez how often she and Hilary have intercourse.

> Dr. Meredith looks over the forms Hilary and I have filled out. She apologizes once more for having sent Hilary a male questionnaire. We had amused ourselves with it, answering probing questions about Hilary's male factor infertility. *How many times during the week does she ejaculate on average?* And STDs? Any unfortunately located varicose veins? …
>
> Dr. Meredith asks me everything about my life: alcohol consumption, cigarettes, the age of my first period, the number of days in my cycle, how my mother died, the intensity of pain of period cramps, vaccinations, family birth defects, *how often I have intercourse* (pp. 64-65, my italics).

The assumptions of the heterosexual matrix are so commonplace, so taken for granted in this setting, that even when a clearly lesbian couple, who lack the body parts necessary for traditional heterosexual intercourse, are sitting in front of them, these medical professionals continue to ask questions about ejaculation and intercourse.

"Coming when you are called," a generic act that seems simple enough, can become complicated and potentially distressing when you are called by a name that is not yours, or by use of the wrong pronoun and/or assumption of the wrong gender. Hailing a subject in the waiting room works to recruit some bodies more than others. Sam describes being consistently called by the wrong name: "Even though on my chart it would say 'Sam' and then my legal name beside it in brackets, and they had highlighted 'Sam' and put it in bold, people would still call me by my legal name."

Ahmed describes how sometimes doing diversity work involves having to "insist" on belonging to the categories that give residence to others. "If you point out the failure to be given the proper title, or if you ask to be referred to by the proper name, then you have to insist on what is simply given to others" (2012, p. 177). For example, Sam tells of how, even after he has "insisted" that his chart be corrected to list only the name he wants to be called, staff continue to call him by the wrong name:

> I spoke to them about it like *so* many times. And it was only this year that finally I was like "Can you print new labels, with my legal name not on it at all?

> Because when you need to do an OHIP billing, you can open the file and then you can find out what my legal name is… so then my name on the chart was what they have to read out, because it's the only name on there. So then they would feminize it and call me [*incorrect pronunciations of his name*]...like anything other than Sam…because it couldn't be Sam…which was sort of bizarre.

Being called by the wrong name usually implies being assumed to be the wrong gender. Sam is consistently assumed to be, and treated as if he is a female subject, a cisgender woman trying to get pregnant:

> The head nurse there— she's really nice. She's so friendly. But she didn't get it. She just could not get my gender... no matter how many times I spoke to her about it. And I can remember her saying, "oh you know, this cycle isn't that good. You know, *if it was my daughter*, I'd tell her don't do it this cycle" or, you know, "You're going to be *a mom*! That's fantastic!" Like, she just couldn't get it.

I.D. documentation can cause complicated difficulties for trans people, especially when documents from different agencies, institutions, or organizations that keep data about people or produce identity documents conflict with one another. As Spade (2011) points out, this happens often because of inconsistent criteria for changing the gender marker on documents. "As a result people rarely have a consistent set of documents that correlates to their current gender" (Spade, 2011, p. 144-45). Stacey's experience highlights this:

> It's possible that at the time my documentation was being changed over, and, you know, some of my documentation might have been one, some might have been the other, because documents have different criteria in Ontario.

Spade (2011) reiterates the difficulties created by the gendered assumptions embedded in forms, the fact that "from birth to death, the 'M' and 'F' boxes are present on nearly every form we fill out," and "the consequences of misclassification or the inability to fit into the existing classification system are extremely high (p. 142). For Stacey and Nina, the consequence of Stacey's inconsistent I.D. is a fundamental misrecognition in the fertility clinic:

> Stacey: Well, I mean, there were tons of factual inaccuracies in all our documentation and everything. I had a health card that lists me as female

> correctly and on their charts they always had me listed as male. So we told them that actually that's not correct, according to my documentation and everything. And instead of apologizing or trying to remedy the situation, they were defensive about how difficult it would be for them to do that... to change their records and so on. So they wrote down, basically, that [my partner] was a heterosexual woman — which she's not— and that I was...uh…"the father"...the potential father who has, you know, sperm problems or something.
>
> Interviewer: So they refused to change it over for the whole course of your treatment?
>
> Stacey: Exactly. And so whereas we expected to be "the moms," instead it became Nina as "the patient" — who was privy to all the information — and me as the well… I wasn't allowed to have any information… because they only could conceive of there being one mother, I think…The idea was that there was *the* mother, not *a* mother. They didn't want to refer to me as the "father" but they just didn't have a term for me. So it was always "the mother" and my legal name.
>
> Nina: Yeah, they wanted to treat us as *a straight couple with male-factor infertility*.

Stacey and Nina are interpellated in the clinic as "a straight couple with male factor infertility." Their presumed body parts lead to their categorization as "straight," and because insemination (not intercourse) is their chosen method of conception, they are categorized as having "male factor infertility." In fact, they are not straight, have no problem with sperm quality (the reason for a diagnosis of male-factor infertility), and are not dealing with "fertility issues" at all. Because they are identified as "straight" and not as two women in a lesbian relationship (which is how they view themselves), Stacey is not recognized as a "mother." In fact, the clinic staff can find no language to describe her parental role.

Because they are treated as heterosexual subjects, they are presumed to engage in normative sexual practice, that is, heterosexual intercourse, and they are told to go home and have "sex":

> Stacey: They were very also interested in us making an effort to get pregnant at home... which wasn't anything that we expressed an interest in. She wanted us to have sex and get pregnant… and we were like, then why are we at a fertility clinic, you know? But they really consistently perceived of us as a straight couple with male-factor infertility... because that's how their system is set up.

Sam, a trans man, whose partner is a trans man, is also advised by a doctor filling in for his regular physician to go home and have "sex":

> He just assumed that my partner was a non-trans guy... and that I was a woman. And so he said "Have sex today, have sex tomorrow, have sex the day after. And then come back and see us." Like, it was...nothing.

Sam also notes that, particularly when he showed up at the clinic without his partner, he was "100 hundred percent 'mommy' to them."

So, Stacey, a trans woman who sees herself and her female partner as both "moms," in the clinic is "not mommy," Sam, a trans man, *is* "mommy." Sam and his partner Rob are not recognized as gay men (even though they are two men in a relationship); Stacey and Nina are not recognized as lesbians (even though they are two women in a relationship). And yet lesbian and gay couples are fairly common place at most downtown Toronto fertility clinics (estimates run from 15 to 30 percent of clients). The lesbian couple, in particular, is certainly not an unrecognizable relationship configuration. Stacey and Nina muse about why, as Nina's partner, Stacey was not given access to information about the process they were going through, and why their lesbianism was so unrecognizable:

> Nina: I think it's partly because you weren't the body that they're getting pregnant… and that's sort of how the model works... the body that's getting pregnant is the patient.
>
> Stacey: I think their idea is that in a heterosexual context they want to safeguard the woman's privacy, make any domestic issues the purview of the woman — but that didn't apply to a lesbian context, which they weren't really ready to think about**.** *I think me being trans made it harder for them to see this as a lesbian context.*

Through this quagmire of misrecognition it becomes clear that part of the problem, for both couples, is the conflation of body parts and gender. Gender, in this case trans genders, trans femaleness and maleness, cannot be recognized separate from body parts. Body parts = gametes = sex = gender = sexual orientation = sexual practice. Because Stacey is providing sperm, her femaleness is unrecognizable. Because Sam is getting pregnant, his maleness is unrecognizable. Practitioners in the clinic are unable to separate body parts from gender identity from sexual orientation and sexual practice. Two people who both possess female body parts can be lesbians; a trans woman and her female partner, cannot. A trans man who is trying to get pregnant, despite the fact that he has insisted over and over that he be addressed by his name and gender, is still seen as female and as "mommy," and he and his male partner are not recognized as being in a same-sex relationship. Both as couples and as individuals, people are misread in terms of sex, gender identity, sexual orientation, sexual practice, parental status, and family configuration. The fact that this is not surprising, given a social context of conventional gender norms and trans erasure, invisibility, and discrimination does not make it any less painful or violating of the people who are misrecognized. The gender work that might validate and bolster the gender (and other) identities of Sam and Rob, and Nina and Stacey, is markedly absent, and within the heterosexual matrix all of them are subject to ruptures or fissures in "aspects of personhood that are cared about deeply and guarded carefully" (Thompson, 2005, p. 201).

Hyper-conventional Gender in the Clinic

Ward (2010) argues that *all* genders require work, and as I summarized earlier, Thompson (2005) suggests that the gender work in fertility clinics relies on hyper-conventional understandings of sex, gender, and kinship in order to help secure damaged or threatened masculinities and femininities. Conservative, stereotypical, and, Thompson suggests, *parodic* displays of masculinity and femininity, and motherliness and fatherliness, work to stabilize gender in the face of innovative, potentially scary, and denaturalizing technologies and the related destabilizing of biological sex *and* social gender (pp. 142-43).

Nina, a cisgender woman in a lesbian relationship with her partner, Stacey, describes feeling that she does not fit what she observes to be the expectation of the "hyper-feminine patient of a fertility clinic." In particular, she comments on the expectations that a female body should be accompanied by a particular set of feelings about that body, as well as feelings about pregnancy and motherhood. She suggests that *all* clients suffer from these expectations, and would be better served by an unpacking of the assumptions about the relationship between body parts, gender, and feelings:

> I feel like they produce appropriate feminine subjects, right? Through what they expect to encounter and I think that some women don't push back against that at all and just, like, give in to it. But it made me really uncomfortable…
>
> A lot of what went wrong for me was the collapse of what my biology could do reproductively with how I felt about it… Like I'm not trans-identified at all and I still have a tremendous amount of difference from what the models are of how a woman's supposed to feel about her body.

Underlying these expectations of conventional femininity, one is likely to find the devaluing of women that typically accompanies them. Jenny Horsman (1991) in a short piece about her journey through the fertility clinic as a cisgender woman with a male partner, describes lying in the stirrups during an uncomfortable procedure and having the doctor tell her partner "that he should take me out to buy me a silk blouse as I have been through a lot to give him a son" (p. 23). The use of hyper-conventional notions of gender can mean a related belittling of women. At one point a nurse tells Nina that she is a "good girl" after she ovulates. In all likelihood the intent of this remark is to congratulate and affirm Nina's gender and her being one step closer to motherhood; her body has performed the womanly act of ovulation, has produced an egg, and is cooperating with treatment and with expectations of womanliness. In Nina's case, however, this "gender work" is not effective and it certainly does not work as an affirmation. She feels belittled in being referred to as a "girl" and unrecognized in her own gender identity, sexual orientation, and relationship status.

Stacey echoes Nina's sentiments about the problems that arise when you do not look like what a mother is expected to look like:

> I have to guess here, because I don't know what's in people's minds but I think for the way I've been received in all these various institutions, I think it has to do with generally not looking like what they expect a mother to look like… it happens to be located around transsexuality for me, but it could be located around other kinds of identity markers too. And when there's that lack of recognition, then there is suspicion that follows it, you know. And that's just always made the experiences really uncomfortable for me.

Jimenez, a butch-identified woman, also describes a sense of not belonging, a feeling of illegitimacy, of not being the one who is expected. For her this is partly due to entering the fertility clinic context without a diagnosis of "infertility," but much of it is also related to gender and the sense that someone of her gender does not belong:

> I don't want to be part of this group. I'm hoping for this to be nothing more than a brief visit into their land. Before they make any assumptions about me, I think I should confess that I don't necessarily have fertility problems. I may or may not. I have virtually no fertility history whatsoever. I'm not exactly like them. I'm not like them at all. I'm not really a woman even. I'm a lesbian. I'm a butch. I'm an imposter. Nothing more. (2011, p. 64)

Jimenez, Nina, and Stacey are all at the receiving end of what I would call "gender work gone wrong." The reliance in the clinic on notions of hyper-conventional femininity leave them feeling uncomfortable, deeply misrecognized, and, I would argue, block the flow of their movement through the clinic.

Body Parts: The Pelvic Exam/Ultrasound

According to Thompson's analysis the pelvic exam, vaginal ultrasound, and other forms of diagnostic procedures are examples of clinic practices that involve an objectification of a patient's body parts in service of a long-range self. Patients cooperate in their own objectification, in the separation of their body parts from their social identities, in order to gain valuable information about the workings of their bodies and in service of the long-range goal of achieving pregnancy. Thompson suggests that objectification can involve agency as long as there is no rupture to personhood — no violation of subjectivity.

This is how Sam, a trans man, describes his experience during a hysterosalpingogram (a test now carried out routinely in most clinics to assess the state of the fallopian tubes):

> At our first appointment he suggested that I get a hysterosalpingogram where they inject dye in your uterus and flush it through your fallopian tubes and see if there's blockage. My partner couldn't come that day, and I was like "this is not a trans-friendly environment." …So he (the doctor) was really struggling to get at my cervix. And it was painful. And when he finally was able to grab it—right when he started doing the spreader, he said, "So, have you heard anything about this trans guy in the States who's pregnant? You guys don't want that kind of publicity, do you?"
>
> And I was like "First of all, you're... you're actually inside my body at this moment and, you know, I'm actually not here to…um…be on TV. We want to have a baby and that's why we're here... that's why we came to you"… And I'm alone. And let's say that, hypothetically speaking, I *did* want to be on TV — which I didn't — is *now* the time to have a conversation about what we could negotiate? Like, this is *so* inappropriate in a million ways. He was inside my uterus, like a thing that usually is only for pushing out… something was going in. And then like two seconds after, he said "Look there's your uterus on the screen." And then I left and I called Rob, and I was like "Holy Christ!"

Sam's description suggests that, in this instance, the "objectification" of Sam's body parts is not working — the doctor is unable to separate Sam's body parts from his gender identity. Unable to focus solely on the information to be gained from the procedure at hand and the body parts in question, the doctor is hyper-aware that he is performing the hysterosalpingogram on a "trans" person, a person whose gender identity does not fit the normal parameters of the clinic. As a result, the procedure does not primarily assist Sam to gain access to useful information about his body (though he might gain such information), but serves also or instead to mark him as "other," as the one not expected, the one whose presence violates the norms of the clinic.

In a sense, Sam's complaint might be that he is not being objectified "enough." That is, the doctor is unable to see *only* his body parts — he cannot fail to be aware of the trans body and identity attached to them. His questions about their desire for media attention serve to categorize the couple’s presence in the clinic as something of a spectacle, an event so out of the ordinary that the media might want to spread the word. His question, “You guys don’t want that kind of publicity, do you?” on the one hand, might be read as acknowledgement of their gender (i.e., “you guys”). But it could also be read as a questioning of their motives for pursuing pregnancy. (Are they doing it for the publicity? As a novelty?) What seems front and centre in the doctor’s mind *is* the novelty and unusualness of the situation and of the body/gender of the person in front of him. Sam, who is enduring a painful and uncomfortable procedure, has no desire to think about publicity. In his mind he reminds the doctor that “We want to have a baby and that’s why we’re here...that’s why we came to you.” The doctor, however, is unable to see this body as just one more in the line of bodies wanting to get pregnant; this body is attached to a trans identity, and one might imagine that this leads him to think about what he knows about trans men and pregnancy, which largely comes from the news coverage of Thomas Beattie and his pregnancies. What results might be called “failed objectification” or the tenacity of the heterosexual matrix’s assumptions. Because Sam’s gender does not “match” his body parts, his body parts cannot be separated from his gender, as they would be for a cisgender person having a hysterosalpingogram. The rupture to the doctor’s assumptions about which body parts match which gender results in a magnifying of Sam’s “difference” at the moment where he probably just wants to get through the test and continue his flow through the clinic.

Jimenez (2011) also has an uncomfortable time when she goes for the routine vaginal ultrasound. The waiting room for a vaginal ultrasound could be classified a “sex-segregated space,” one of the areas Spade (2011) identifies as potentially difficult for those who are outside conventional gender. Jimenez describes her ultrasound experience like this:

> I am terrified of the ultrasound. I know it involves taking off my clothes, and letting them stick some plastic contraption inside me. A friend of mine told me

> that it's not as bad as a speculum, that it's not as big, that it's smooth, that there's lube. An info sheet advises that it is a painless procedure. The physical aspects of the exam are not what worry me. I would be reassured if I wasn't so neurotic. *I will do anything to make this baby,* and this urgency will allow me to overcome the ultrasound procedure, but that doesn't mean it will be okay.
>
> The woman at the sign-in finally calls my name…she leads me back to a small office with an examining table and computer screen. She directs me inside, but she herself stands at the door. I am a trapped, scared animal in this tiny medical room, looking back at her… "Take down your pants and your panties," she commands, "and I will return."… I cringe. I hate the word "panties." It makes me think of being a young, vulnerable girl, with some tiny, pink piece of cotton covering me up. I don't wear "panties." I wear boxers, thank you very much. I'm not about to talk back to her though. (Her) tone is clear and certain. She has directed me and I am to comply (pp. 67-68.)
>
> A contraption made for women used to dicks inside them. And I think, *oh man, I'm an anomaly as a butch. I have a small hole. There aren't enough of us to mold a tool just for us.* I'm not saying this makes sense. I'm sure a lot of women could benefit from something smaller. But I forget that, because I feel queer in this office with feminine women, real women. I feel like another kind of animal (2011, p. 72, my italics).

Jimenez understands that being a "good" patient at the fertility clinic means complying with instructions, and she is willing to "do anything to make this baby." She wants to cooperate with this process of objectification — the ultrasound, which, though she is afraid of it, will potentially provide her with important information about her body. But the reference to "panties" implies a kind of femininity with which she does not identify; it ruptures her sense of herself and blocks her movement through the clinic. She feels like an anomaly, something "queer," "another kind of animal." Clearly she is a gender outsider in the clinic, not the hyper-feminine woman of conventional gender, the woman whose femininity is welcomed in the clinic—another example of failed gender work. Nothing in her clinic experience affirms her gender identity; instead her outsider status is exaggerated and she, like Sam, due to the misrecognition of her gender, is not able to benefit, in a simple way, from the "objectification" of her body parts.

Nina, a cisgender woman, is very aware of the ways that her body is objectified in the clinic, but goes on, interestingly, to suggest that it would be ideal if she *could have been just treated as a uterus*:

> I would say that there was a complete objectification of my body. Like, the only reason I needed to be there was that my body needed to get pregnant. I don't even think that they were dealing with me, it's that they were dealing with my uterus. And I was carrying my uterus, so I had to be there, Stacey didn't.
>
> Actually I would have been fine if they were looking at my uterus-as-a-uterus as long as it wasn't a uterus that had to be attached to a woman who felt a certain way about having a uterus. *Like that actually would have been ideal… if I was just treated as a uterus.*

Nina, in a sense, echoes my own argument. In order for all patients in the fertility clinic to have access to processes of objectification that might assist in their flow through the clinic, the linked and deeply embedded assumptions of the heterosexual matrix — the assumptive links between body parts, sex, gender, sexuality, sexual practice, etc. — need to be disentangled and separated. Nina wants to be treated "just as a uterus," separate from ideas about what a person with a uterus feels about their body, about parenthood, or where they sit in relation to femininity or masculinity.

Meeting with the Doctor

While the numbers of female physicians in Ontario fertility clinics is rapidly increasing, the field of reproductive medicine has historically been extremely male, and many clinics continue to be headed by male physicians with predominantly female staff. As a result, the sites themselves are highly gender differentiated and stratified (Thompson, 2005, p. 122). Part of being the "good patient" in the site is managing one's relationship with the doctor. As Thompson notes, civility is a huge part of appropriate patient comportment; inappropriate behavior includes arguing with the doctor or with one's partner (2005, p. 91). Thompson describes how female patients, in relation to the doctor, "willingly accept the role of being the object of the medical gaze and in fact actively participate in it.” She quotes a clinic nurse who comments that almost all women patients flirt with the doctor, want to be thought of as attractive and womanly, and to be compliant with and special to the doctor. For men, “a certain amount of male bonding between the usually male physician and the male patients was considered appropriate too” (p. 134).

Horsman (1991) describes her and her male partner’s visit with the fertility doctor:

> The doctor shook my partner’s hand. He didn’t seem to think there was any need to shake mine. After we had given our history, while I went to undress to be examined, the doctor chatted to my partner about the causes of our infertility — not to me. At the end of the appointment, again shaking my partner’s hand, he said we were kind of a nice couple and deserved to have children and he was sure he could help us. I wanted to ask him what factors made us “kind of a nice couple?” Our heterosexuality, our white skin, our middle-class backgrounds, our education level? There was a clear implication that this was a process only for those he considered “nice.” (Horsman, 1991, 24)

In this heterosexual context, the doctor bonds with the male partner, provides him with medical information about their case, and deems them a “nice” couple — which, as we know, as his female partner knows, and as Thompson puts it, “nice” stands in for “appropriate” patients, the ones who can pay and whose civility stands “in proxy for the baby-centered heterosexual nuclear family” (Thompson, 2005, p. 92).

Sam, a trans man, describes his fear of making the doctor mad:

> We had seen our doctor yell at another couple when he was leaving their room, rushing to the next room. They were, I guess, having the gall to want more than four and a half minutes with him, and we don’t know what their question was, because we didn’t hear that part, but we heard him say “Look, just relax! Okay? Just relax!” And then he stormed out of the room. So, to be honest, a lot of my time there was really trying to just run away from ever having that experience with the doctor. I never wanted him to talk to me that way because you’re so vulnerable in that moment. And then I would most likely cry — which I did not want to do in front of him.

Sam is describing a vulnerability clearly shared by many fertility patients in relation to the doctor. The doctor holds the key to the knowledge, instruments, and procedures which may lead to pregnancy and/or parenthood, and negotiating the clinic environment includes negotiating one's relationship to the doctor. However, for queer and trans people there is added vulnerability produced by the processes by which they and their family members are misrecognized and disregarded. For example, Stacey describes how she feels negated by the doctor's reference to her "transgender stuff":

> The doctor was really not educated about what it was to deal with trans clients. For example, when we were going over our medical history... this is a verbatim quote: "your transgender stuff"… was basically my medical history. First of all I don't identify as transgender, I more identify as transsexual, so she kind of invented that term. And you know the idea of "stuff" just kind of negates the experiences.

Trans clients can be additionally vulnerable due to tensions I noted earlier related to complicated decisions to continue or postpone a transition process in order to freeze gametes or get pregnant. For some, part of a decision to pursue parenthood means stopping or forestalling desired hormone treatments. And sometimes doctors are not aware of the medical implications (or lack of them) of such decisions, but make recommendations regardless. Stacey refers to a doctor's recommended line of treatment like this:

> So regarding my hormone regimen, she recommended that I stop taking any hormones, specifically Finasteride, which is a very specific anti-androgen that some trans women take and it basically prevents hair loss. It doesn't affect sperm quality and a lot of non-trans men would use Finasteride. It only blocks a very specific part of testosterone receptors in the body. But she wanted me to discontinue this… and so she wanted to make the calls about how we were going to get pregnant… and wanted to, I guess, instruct us on what sort of lifestyle choices we should be making, in terms of stopping HRT, basically.

While Stacey is addressing an ill-informed recommendation from a doctor, Rob and Sam contemplate the complicated decisions Sam had to make about stopping hormones in order to get pregnant:

> Rob: I know for you [Sam] to have kids would mean going off testosterone and stopping that whole transition process…in some ways it was a little bit complicated…

> Sam: Yeah, and I had started transitioning really early…most people I know started transitioning six or seven years after me — but they pass completely whereas I don’t at all because I’ve been off hormones for so long now. So, it was a hard decision…you know. Now I’m pregnant and it’s wonderful, but there are times where it has been frustrating — because he [Rob] has been able to continue his transition.

Stopping hormones makes it more difficult for Sam to pass as male and probably contributes to his frustrations with clinic staff who resist using the correct name and pronoun to address him. Once again, a different kind of gender work that took care to affirm and bolster his gender identity might have an enormous impact on his experience in the clinic. Sometimes gender work involves micro-actions, small gestures that affirm or deny gender, and that have come to be associated with gender difference. Horsman describes how the doctor shakes her (male) partner’s hand, but not hers. When Sam and Rob are ready to leave the clinic, with Sam successfully pregnant, the doctor gives Sam a hug, and shakes Rob’s hand.

> Sam: And then at the end, he shook my partner’s hand and gave me a hug. And it’s not that I don’t mind getting a hug, but I was like “You could’ve given us both a hug. But what you’re doing here is you shake the man’s hand and you hug or kiss a woman.” And because I’m pregnant, then I’m a woman. Because he’s not pregnant, then he’s a man. So that was a bit annoying.

It is perhaps a small thing, and understandable given the hyper-conventional gender norms that swirl about in fertility clinics. But for Sam, the hug from the doctor is one more small denial of his gender.

Sex-Segregated Space (Invaders): The Andrology Lab

As Spade sees it, sex-segregated spaces can present extreme difficulty for trans-identified people. The sex-segregated bathroom is probably the space most commonly cited as a source of misrecognition and even violence. As Cavanagh puts it, “Those who are recognizably trans are subject to persecution for using the ‘wrong bathroom’ in ways that are not only callous and cruel but compulsive and curious” (2010, p. 7). She argues that the heteronormativity governing the gender of urinary designs in North America reproduces the heterosexual matrix…a means of sorting bodies into two divergent and mutually exclusive gender locales (p. 7). Of course it is not just trans people who have difficulty in sex-segregated bathrooms. Anyone who can be read as other than cisgender and heterosexual can be at risk. Cavanagh cites an example from Nashville, Tennessee, where a straight man using a men's bathroom, holding his fiancée's purse and guiding a blind male friend, ended up shot to death by a man hurling anti-gay insults (2010, p. 9). Clearly, being the wrong sex, gender or sexual orientation in a space designated for the other can have grave consequences. In the highly gendered environment of the fertility clinic, sex-segregated spaces include bathrooms, the waiting room for vaginal ultrasounds, and, of course, the andrology lab (where sperm samples are collected).

In an early account of fertility clinic experience, a heterosexual man describes how much more attention is paid to his potential contribution to infertility, than to that of his wife:

> And he (the doctor) is far more sensitive to me in some ways than to Emma. He was very matter of fact about her endometriosis and irregular menstruation, but turned on all his most sensitive charm in breaking the sad news that on one occasion I had a low sperm count. It's so silly, but I responded in exactly the same way Sylvester Stallone would. I wanted to say, "Let me do it again, I'll show you!" (Basen, Eichler, Lippman, 1993, p. 41).

In contrast, Stacey, a trans woman, describes her visit to the andrology lab as a "bizarre experience," and as a place of misrecognition and awkwardness:

> They sent me to the andrology lab and they were kind of confused to see me there because I'm not usually who shows up in their department... and then when she did see the sperm samples I remember her congratulating me on my genetic material... as though I would identify with it in any way… which just felt odd. They referred to the sperm as "the boys" every time, and congratulated me on "the boys."

Once again, what is most likely intended as a gender affirmation, a congratulations to Stacey for the production of her "genetic material," goes sideways when her sperm sample is referred to as "the boys," a reference that furthers the alienation she is already feeling ("as though I would identify with it in any way").

Andrea, a trans woman interested in freezing sperm before her transition, talks about the problems with the pornography:

> The pornography that they have for, um, inspiration? Yeah, well 25 magazines if you're into the objectification of women. But pretty much nothing else. And I came out of the room laughing after like ten minutes…even just having them on the table is distracting… And I go up to the reception and I'm like, "Do you have anything that *doesn't* have women in it?" And, of course, they did not.

The andrology lab becomes a site of both failed objectification and failed gender work. The separation between Stacey and her gametes, a separation that ordinarily "makes possible events that would not otherwise occur" (Thompson, 2005, p. 197), is not able to occur in this instance without a rupture to her personhood. And the gender work performed in the andrology lab, ordinarily designed to bolster, affirm, and enhance heterosexual masculinity, does not work for those whose genders and sexualities fall outside of it. Instead, individuals are deeply misrecognized and their subjectivities violated. Processes are not in place that might, in the service of a long-term self, facilitate the objectification of gametes, body parts, etc. outside of the heterosexual matrix's assumptions. Such processes, in combination with the appropriate gender work, might create a space that offers legitimacy and recognition to a broader range of gender and sexual identities, thereby facilitating their flow through the clinic.

Strategies to Benefit the Long-Term Self

While my focus has been on the processes by which queer and trans people are misrecognized and violated in their interactions with fertility clinics, I recognize, of course, that these interactions are multifaceted and involve complex negotiations at every stage. The interviews with the people included in this chapter suggest that, beside or in addition to objectification (that might benefit a later self), people adopt a range of strategies in negotiating their way through the clinic. If we accept Thompson's suggestion that ethicality be evaluated based on rupture (or not) of personhood, then exploring the impact of some of these strategies can reveal another dimension to queer and trans experience in clinics. My aim is not to undertake a full exploration of this subject (i.e. *all* the strategies COF interview participants adopted), but to suggest that, besides objectification, there are other strategies that people adopt, in service of a long-term self, that may contribute to violations of their subjectivities.

In an earlier example, Nina gestures toward the desire to disentangle the assumptions of the heterosexual matrix from objectification of her body parts — she would prefer to be seen "just as a uterus," rather than as a person with a uterus who is supposed to feel a particular way about that body, about womanhood, motherhood, or gender. She and Stacey acknowledge that

> *on a technical level* things went smoothly. They have tons of toys that they know how to use. But on the interpersonal level, it was so frustrating…on multiple occasions we really wanted to abandon the clinic and start again somewhere else. But we didn't want to go back to square one.

They make a distinction between *the technical* and the *interpersonal*, and, in the end, they chose to put up with the interpersonal, with the layers of misrecognition, and to persist with the clinic in order to achieve their long-term goal of pregnancy.

Dan, a trans man still trying to get pregnant, describes how, on some level, he wants to think about the process as just being about "sperm and egg." He does not want to think about the ways he may be being treated poorly, he "blocks that out" because he wants to think he is getting the best possible treatment:

> The friend that lent me the money, she was saying "Well, of course you're going to get lousy treatment...because you're trans, because you're queer, because you're not following the rules, because your partner isn't your sperm donor. Of course you're getting bad treatment."… And I feel foolish to think there *isn't* more to it, but my brain always goes to "There's sperm and egg and either they work or they don't work. And what else is there?" But it is possible that I'm

> getting poor treatment because I'm queer and trans and not following the rules, and my partner isn't my sperm donor. But I… I don't know. Again, self-preservation…I block all that out and I just think "Hey, sperm, egg, it's not their fault it's not working. They did what they could."

Of course there is no way to evaluate the "truth" of Dan's experience in the clinic; what seems important is his description of how he is "blocking out" thoughts about how is being treated and choosing instead to focus on the technical aspects of things, the "sperm and egg," as a "self-preservation" strategy in benefit of the long-term self.

Sam also adopts the strategy of "tuning out" the ways he is being misrecognized in the clinic. After some events they experience as "traumatic," including the clinic's losing the results of their miscarriage, his partner, Rob, decides not to come to the clinic anymore. Sam goes by himself, but describes himself as only "half there":

> You know, it's so early in the morning, you're going every single day— by the end, I just brought a book and just tried to *tune it out* because it was easier than fighting every single time that I went there.
>
> There's so much trauma — my partner didn't want to go back to the clinic *ever* again. So when I decided to go back, I knew I was going in there by myself — not by myself because my partner was with me — but not physically there…So I brought a book. I got Monopoly on my phone and I just went in there with a very different attitude. And I tried not to get involved in all of the stuff that was happening around. I brought stuff for my own entertainment. So then I was sort of like *only half there anyways.*

When you are hailed by a name or pronoun that is not the one you identify with, or assumed to be a gender or a sexual orientation that does not fit, the process of generic bureaucratization, of assimilation into the normal routine of the clinic, is interrupted. Once this flow is interrupted, it becomes more complicated to "behave within the normal parameters" for the clinic. When you are a body that is "diverse," a body that is not expected, or that causes "blockages" in the flow of systems, you face many moments of decision and/or indecision in your encounters with institutions. Or, as Ahmed puts it, you face hesitation:

> There is a labor in having to respond to a situation that others are protected from, a situation that does not come up for those whose residence is assumed. Do you point it out? Do you say anything? Will you cause a problem by describing a problem? Past experience tells you that to make such a point is to become a sore point. Sometimes you let the moment pass because the consequences of not letting it pass are too difficult. (2012, pp. 176-177)

In pointing out a problem, in making a point or asking to be treated differently, one runs the risk of *becoming* the problem, of confirming that one does not really belong:

> Not only that, you are heard as insistent, or even as self-promotional, as insisting on your dues. If you have to become insistent to receive what is automatically given to others, your insistence confirms the improper nature of your residence. (Ahmed, 2012, p. 177)

Sam describes this tension between speaking up and keeping quiet, between being vocal about his concerns and his dependence on clinic staff and procedures to achieve his long-term goals:

> I was very careful. I could have been way more vocal about them getting my gender right, getting my name right. I could have been way more vocal about a lot of things, but *I needed them.* At the end of the day, every single day, they're going to stick a needle in my one vein. And they're also going to probe me, for the vaginal ultrasounds. So, you know, I was as outspoken as I could be, without making things too much more difficult for myself.

For Dan, his long-term goal of having a child takes precedence over how he is recognized or misrecognized in the clinic:

> For queer-trans reasons, I wasn't very concerned. I thought... whatever they call me, I just want their help. And if they want me to be female, I don't think I'm going to say anything. And if they want to call me the wrong name… the priority was having the kid and if they treated me respectfully... or took my concerns seriously...I was less worried.

Each of these examples involves a decision to "put up with," "ignore," or "tune out" moments of rupture to personhood. In each instance, the people involved choose to "ignore" in order to benefit their long-term self, the self who desires to be pregnant. If ethics in these situations is evaluated based on rupture to personhood, one could say that some of the strategies deployed by queer and trans people as they make their way through the clinic involve a breach of ethics —

that people are put in a position, in a sense, of collaborating in the violation of their own sense of personhood in order to benefit their long-term self.

Making decisions to "not" speak out on one's one behalf can have effects. Stacey and Nina each recall their experience in the clinic differently. Nina recalls having more of a sense of humour about the whole thing, and "wanting to get in and out as quickly as possible, and not engage with how they saw us." Stacey is more confused and surprised by how they are treated, and ends up feeling bad about her lack of intervention:

> I just felt confused and, you know surprised each time it happened. And it always was a little bit subtle and just kind of in the midst of other treatment and so on and we didn't really want to necessarily stop the treatment. We just wanted things to work differently…uh…interpersonally. As so I just wasn't prepared to deal with it, I guess. And so I didn't...which *left me feeling bad about that part of the process.*

Dan, after having a bad experience with one doctor, describes his fears about making a request to change doctors and his shame in not being more assertive:

> I was nervous to justify why. I didn't want to be told, "Oh, that's not good enough," or "Oh, you're being a difficult patient, we're kicking you out of the clinic."…Really, she rubbed me wrong for a long time. And just being stubborn, I hadn't changed anything. There was the occasional day where I would go in determined that I would get my questions answered. And she'd just start talking and talking and talking…*I was starting to feel ashamed that I wasn't asking my questions of my doctor*.

Jimenez (2011) talks about how she feels after asserting herself in relation to the clinic by letting them know she wants to cut down on her days of cycle monitoring and that she wants notice if her doctor is not going to be the one inseminating her:

> I do better when I feel I have some control, and this time I did… I spoke. I acted. I imagined myself to hold some role in the medical procedures conducted upon my body. *It's only taken me a year to get some balls.* (p. 83, my italics)

Stacey and Nina refer to another couple they know, "two trans guys who are really active," who were very "proactive," who knew how to self-advocate in relation to birth registration:

> They came in knowing what they are entitled to, what their rights are and so on. So they had a better experience than us… I think they came in knowing a lot more how to negotiate things for themselves.

Each of these people feels that in some sense they have let themselves and/or their partners down by not being "better" at self-advocating, at speaking up on their own behalf, and challenging sooner the places and moments in which they are misrecognized or disrespected. I wonder if there is a culture in some outsider communities that includes a sense that one should "stand up for oneself," know how to self-advocate, and take some control in a situation in which you are being treated unjustly. In situations where one does not self-advocate, it can amount to another form of violation: not only are you being mistreated, you feel that in some way you are violating yourself by not speaking or acting up. Perhaps in moments of mistreatment or lack of recognition there is a loss of dignity, or a rupture to one's identity as someone who does stand up for oneself, who knows how to self-advocate and assert oneself. Thompson judges the ethicality of objectification based on whether or not an individual is able to maintain synecdoche with the goals of a long-term self, to maintain a sense of personhood in the face of objectification.

People deploy the strategies I described here in order to negotiate a journey through the fertility clinic, a journey marked by the long-term goal of achieving pregnancy. It is not possible to evaluate the ethicality of these strategies apart from the subjectivities of the individuals involved. And, as Thompson notes, people's feelings about an experience can change over time, sometimes influenced by the passage of time and potential outcomes. The question, however, is useful. When queer and trans people negotiate their way through the institutional environment of fertility clinics, at what points do the ruptures to personhood that they might experience amount to a breach of ethics?

Chapter 4. Queer Kinship in the Fertility Clinic: Policy and Administrative Practices that Erase Queer and Trans Families

Chapter 3 explores the gender work typically performed in fertility clinics, most often in service of bolstering and/or repairing conventional masculinities and femininities. This chapter explores queer kinship in the fertility clinic, in particular, how fertility clinics also perform "kinship work" that serves to recognize some biological facts as more relevant than others, and to naturalize those kinship relations determined to be appropriate, while refusing (sometimes knowingly, sometimes unintentionally) the naturalization of kin relations that are unfamiliar or unintelligible. Two examples from the COF data illustrate how such kinship work operates in the fertility clinic and how heterosexual kinship is sometimes naturalized, when queer kinship is not. I also examine the impact of a particular administrative blockage experienced by LGBTQ people in their interactions with AHR services. Specifically, I first use an example of what is sometimes called "lesbian reciprocal IVF" to address issues of kinship naturalization, and second, I explore the impact of the Processing and Distribution of Semen for Assisted Conception Regulations (Food and Drugs Act, 1996) (which, for ease, I will refer to from here as the semen regulations) on the experience of people using known sperm donors and seeking assistance from clinics. I also reflect on some of the strategies deployed by LGBTQ people in relation to these regulations.

In considering these strategies, I return to Thompson's suggestion that ethicality in fertility clinic practices might be evaluated based on whether or not violations or ruptures to the personhood of clients take place (2005, p. 201). Pfeffer's (2012) concepts of "normative resistance" and "inventive pragmatism" are helpful here to differentiate strategies that rely on, versus those that resist, concepts of normalization. Normalization strategies, or "inventive pragmatism," such as those that involve deception about sexual relations and identity, can be costly and/or violating to the self. The act of lying about one's sexual orientation and/or family configuration and relationships means not just being misrecognized, as is common in LGBTQ fertility clinic experiences (See Ross et al., 2014) but being asked to *actively participate in one's own misrecognition.* At the root of the struggles that participants describe is the fact that "known sperm donor" is not intelligible as a kinship category within the institutional framework of reproductive services and legislation, or indeed within mainstream social discourses.

The People

Heidi and Stephanie

Heidi and Stephanie both identify as queer and white, and had been together for over eight years when they decided to try and have a child. For personal reasons, it was very important to Heidi that she have a biological connection to the child, though she had no desire to be pregnant ("just not me," were her words). Stephanie, on the other hand, wanted very much to experience pregnancy, childbirth, and nursing. They found the atmosphere "cold" at the first clinic they went to, but had a more positive and supportive experience at the second clinic. Here they extracted and fertilized an egg from Heidi and implanted it in Stephanie's uterus. The process was financially costly and involved multiple tests, the synchronization of their cycles through birth control pills, and the use of heavy-duty fertility drugs. In the process Heidi discovered she had two polyps that required removal as well as a subclinical hyperthyroid that required treatment and Stephanie developed migraines from the birth control pills. However, they were both extremely committed to the idea of reciprocal IVF, both for the biological implications but also because of legal fears. They had decided against using a known sperm donor because of the legal uncertainty regarding his status, though it was important to them to use an I.D.-release donor so that their potential child could, at a later date, know their biological history. Heidi describes herself as “growing up poor.” She feels funny about spending so much money on the IVF process, and alienated from the clinic process which is “something rich people do.”

Antoinette and Donna

Antoinette and Donna are two queer-identified women in a relationship. Antoinette identifies as white, and Donna as black. They are particularly focused on issues of race in their decision making about a sperm donor and eventually decide that rather than sifting through information about “race” on sperm bank websites, they prefer a known donor. They reject their own “cake-batter race theories,” which assume a certain degree of control over outcomes, in favour of choosing a donor who, although he is different racially from what they initially were seeking, makes more sense for them. They are angry about the barriers they encounter in relation to bringing known donors to the clinic, and articulate several times how much easier and less awkward it would be if they could do medical screening and testing of donors, as well as insemination, through the clinic. They know other people who have misrepresented their donors as sexual partners in the clinic, but are reluctant to do this themselves because of their lack of aptitude for lying, as well as concerns about asking the donor to lie on multiple visits.

Tonya and Jacqueline

Tonya and Jacqueline are two women in a relationship. Tonya identifies as white and lesbian and Jacqueline as mixed race and bisexual. They have decided to use Tonya’s brother as their sperm donor and assumed they could get assistance for this process from a fertility clinic. They are surprised to find this is not in fact the case, and that using Tonya’s brother’s sperm is much more complicated than they anticipated. They are informed by a student who happens to be left alone in a room with them that there is a way around the sperm regulations if they pretend he is Jacqueline’s sexual partner. They are extremely uncomfortable at the idea of lying for several reasons, including concern for the donor and legal anxieties with regard to Jacqueline's recognition as a parent. In the end they are put off by the requirements attached to the use of a known donor (i.e., sperm testing and quarantining and the attached delays, costs, and freezing required), and they successfully inseminate at home.

Lucy and Clare

Lucy and Clare are two white women in a relationship. Lucy identifies as queer, and Clare as bisexual. Their doctor has provided a referral to a fertility clinic, but refers to Lucy as a single woman, which they find "weird." They want to use a known sperm donor and make phone calls to clinics all over Ontario, asking about assistance. For some calls Lucy tells the truth about their relationship, and for others she pretends to have a male sexual partner. When she tells the truth, all but one clinic says they "can't do that." The person who answers the phone at the one clinic who is willing to help advises them to "Just come in with your known donor and tell us he's your sexual partner and we'll do it." They too feel discomfort about lying, particularly because, as Clare puts it, she has spent years lying about who she is. For these women, the concept of "risk" is salient and complicated; they perceive a bigger risk in using an anonymous donor, a person they don't know, than in the potential health risks of using somebody known to them. They want the option to sign a waiver that clarifies they are willing to assume these risks.

Joe and Charlie

Joe and Charlie are two white, trans men in a relationship. Charlie wants to get pregnant. For reasons related to their experience as trans men in the health care system, as well as their preference for a known donor, they ultimately choose to inseminate at home with the sperm from a known donor. However, they do utilize the services of a clinic to test Charlie's fertility, and they explore the options open to them for clinic insemination. A clinic in a large urban city suggests that if they want assistance with insemination at the clinic they can present at the clinic as a “threesome” with their sperm donor. The clinic also offers to do cycle monitoring and to then send them home with the appropriate supplies for home insemination. Another clinic, in a smaller city, presents no options for assistance with a known donor, and refuses to offer them cycle monitoring if they are inseminating with someone who is not a sexual partner. [1]

Naturalization of Kin Relations: Who Are the *Real* Parents?

Franklin and McKinnon’s point (see my literature review, p. 62), that the same substance, mobilized in one context to create kinship ties, may, in another context, be used very differently, and Weston’s (2001) question about how and for whose benefit these processes of “making kin” take place, are neatly exemplified in Thompson’s work on the naturalization of kin relations in the context of fertility clinics.

As Thompson (2005) puts it, “certain bases of kin differentiation are foregrounded and recrafted while others are minimized to make the couples who seek and pay for infertility treatment — the intended parents — come out through legitimate and intact chains of descent as *the real parents*” (p. 145). Thompson uses the example of two technically identical procedures that lead to different kinds of kinship configurations to illustrate how kinship and procreative intent are naturalized in the fertility clinic. In her analysis, the act of carrying a pregnancy and genes are both natural resources in the making of parents and children, but their meaning in establishing parenthood is distributed differently, depending on norms governing the family; laws regulating reproductive technologies, custody and descent; the medical technologies themselves; and, the financial dynamics of third-party, medically assisted reproduction (p.148). She differentiates what establishes parenthood, which she calls *relational*, from what does not

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[1] Dan, who we met in chapter 4 (see page 98), also appears in this chapter.

sustain a parental claim, which she calls *custodial*. In other words, procreative intent combined with financial considerations (who is paying for services) determines who is a parent; the role that third parties might play in this process (i.e., custodial work: providing or caring for gametes and embryos), whatever their "biological" relation to the project, is deemed irrelevant to parental claims. In this process she suggests that nature and culture are co-produced, but that the relation between the two is underdetermined and "eminently revisable."

The examples Thompson uses are a *heterosexual egg donor IVF cycle* (a woman carries a pregnancy conceived from a donated egg and her male partner's sperm) and *a gestational surrogacy* (a woman carries a pregnancy that is conceived from a donated egg — or the egg of the intended mother — and the male partner's sperm). In the first case "motherhood" is conferred based on procreative intent, finances (who is paying), and gestation or biology (substance) — the woman who carries the pregnancy, although she is not genetically related to the baby, is deemed "the mother." Her partner, who provided the sperm, is "the father." The woman who provided the egg plays a "custodial" role, not a parental one. In the second case, the woman who carries the pregnancy (substance) is in a custodial role, while "motherhood" is conferred (if the intended mother did not provide the egg) based on procreative intent, social/legal grounds, and finances, or (if she did provide the egg), on all of the above plus genetics. And of course, in either scenario if the intended father is unable to provide useable sperm, the use of a sperm donor would mean the designation of "the father" based, not on substance or genetics, but on procreative intent and finances. In each instance, certain aspects of substance/biology/genetics are foregrounded and used to bolster parental claims, while others are deemed insignificant in the making of kin. In each case, the kin relationships are naturalized. On some level, it seems obvious and "natural" who the "parents" are.

Interestingly, this process of naturalization does not work in quite the same way when queer people are involved. To begin with, the process of baby making for many queer people requires complex decision making about gamete providers and sometimes surrogates, and always in a context of legal uncertainty. As Heidi and Stephanie put it:

> Stephanie: You always feel like you just don't have as many rights as a heterosexual couple going into it.
>
> Heidi: I mean you constantly kind of have this on your mind: Is someone going to take my baby away?

Heidi and Stephanie made the decision to have a child through "lesbian reciprocal IVF," that is, the egg of one woman is fertilized with donor sperm and implanted in the uterus of the other. Part of their decision to use this method of conception involved a desire to increase legal security. As Heidi puts it, "Given how much we went through to do this, any judge looking at it would say that we both intended to be parents."

Having made this decision and invested significantly — financially, physically, and emotionally — in the process, imagine their surprise, just before the embryo transfer, when they were handed paper work that asked Stephanie (whose egg is being used to create an embryo) to waive her parental rights:

> Stephanie: There was one thing that was sort of troublesome… the paper work that needed to be completed before we went ahead with the egg retrieval and the transfer… There were about five sheets, they wanted me to waive my parental rights.
>
> Heidi: …because the way the paper work is set up is as if it is an egg donation… the forms were either for me to be the surrogate or for my partner to be the egg donor. It just varied depending on which form they gave us.

Recognizing the implications, Stephanie refused to sign the form waiving her parental rights. The nurse told them they had to sign it, then conferred with someone in the hall, who reiterated "They just have to sign it. Why don't they want to sign it?" The two women explained why they were refusing to sign, and eventually the clinic staff allowed them to proceed without signing the form. Heidi and Stephanie explained to the clinic staff:

> Listen, the way that your forms are set up don't work for us. They don't work for other people who are doing this. You need to figure something out, whether you make new forms, whether you make these more inclusive. You've got to do something because you can't ask somebody to sign away rights that shouldn't even be in here.

The clinic responded with something like "we'll take that into consideration." Later, there was confusion about whether Heidi was acting as a surrogate, or Stephanie as an egg donor, some of which seems to be based on financial implications:

> I think it was because that was the cheaper way to do it… like some of the forms would call Stephanie the mother, other forms would call me the mother. And then there were some forms that said "father." We would just cross that part out and write "mother." We did a lot of adapting.

Spade's (2011) analysis of how administrative governance can work to make trans people's lives administratively impossible is relevant here to the experience of these cisgender women. While in the heterosexual instances described earlier (egg donor IVF and gestational surrogacy) procreative intent, combined with finances, serve to naturalize who the parents are (i.e., the heterosexual couple who are paying for services and intend to be parents), in this instance the woman who is both providing the egg (genetic material) *and* is the intended parent, is asked to sign a form that waives her parental rights. There is confusion about who the "mother" is (in fact, there are two mothers), a "father" is inserted sometimes, and all of this takes place in the context of legal fears about one woman's recognition as a parent As Heidi said it, "you constantly kind of have this on your mind: Is someone going to take my baby away?" Similarly, gay men involved in surrogacy arrangements that involve an egg donor, a gestational surrogate, and the sperm of one of the men (the intended parents), find that the man who is providing the sperm gets treated in a clinic setting as if he is a sperm *donor* (i.e., not the *sperm* *provider and intended parent*), and thus subject to regulations regarding the freezing and quarantining of his sperm.

The contrast between the heterosexual and the queer examples gives meaning to Thompson's (2005) statement about the doubledness of reproductive technologies:

> It is no wonder that progressive cultural critics cannot decide whether the new reproductive technologies are best judged as innovative ways of breaking free of bondage to old cultural categories of affiliation or whether they are best denounced as part of a hegemonic reification of the same old stultifying ways of classifying and valuing human beings. The technologies are fundamentally both. (p. 177)

In Thompson's heterosexual examples, where there is potentially more than one answer to the question "who is the mother?" she says that "'procreative intent' propelled the sorting and classifying of some things and not others as the biological facts of relevance" (p. 177). In the queer example, the opposite is true. The biological facts are, at least initially, classified in such a way that one woman's parental claim is denied, within a legal and institutional context in which she is already vulnerable to misrecognition, lack of intelligibility, and erasure. Her partner expressed fears that "someone will take your baby away," and the next thing she knew she was being asked to sign a form that accomplishes exactly that.

Thompson suggests that the biological classifications and strategies that enforce procreative intent resonate with studies indicating that reproduction is already stratified (2005, p. 176). Those with financial resources and the heterosexual matrix behind them up are able to mobilize biological classifications that recognize intended parenthood. Heidi and Stephanie, while ultimately able to proceed with their procreative project, were initially subject to administrative practices that not only denied their procreative intent and rendered invisible their status as two mothers and their family configuration that does not include a father, but also that potentially removed the parental status of one mother.

Ehrensaft (2008) recognizes this phenomenon as part of the heteronormativity of fertility clinic practices:

> The policies at fertility clinics are typically designed with heterosexual, not lesbian, families in mind, as when clinics ask an egg donor to sign away her parenting rights and do not take into consideration those lesbian families in which the egg donor has every intention of being a mother, along with her womb mother partner. (p. 170)

To say that heterosexual families are the families in mind is to recall again the power of the heterosexual matrix, a configuration that is not easily disrupted — the linking of body parts/fluids to gender to sex to family configuration. Thompson suggests that it is the newness of the innovations enabled by reproductive technologies that require a shoring up of the conventional heterosexual nuclear family in order to make "new things seem normal" by interpreting them as "new examples of old things" (p. 141). Processes of naturalization such as those described here bring the sociotechnical innovations of reproductive technologies into the realm of the acceptable. While the meanings of biological relationships are underdetermined and all askew, at least the nuclear family is intact. In the heterosexual context, the *real* (i.e., intended) parents are naturalized, despite complex configurations of biology, genetics, and intention. In the queer context, parents become not-parents, as in the case of Stephanie and Heidi's lesbian IVF. Even more complex is the kinship category of the "known sperm donor," a category that does not fit heteronormative models of the two-parent, gender-dichotomized family.

Donor Decisions

As many have documented (see, for example, Sullivan, 2004; Mamo, 2007; Luce, 2010; Kelly, 2011; Leckey, 2011b; Epstein, 2003 and others), when two women who do not have sexual access to sperm are planning to have a baby together they typically embark on a complex decision-making process regarding the source of sperm. In the Dykes Planning Tykes course, a course designed to assist in this planning process, questions relating to the complexities of sperm donor decisions are of primary concern. The most difficult decision involves deciding between an anonymous or a known sperm donor. Currently in Canada, anonymous donors are available through sperm banks and in two categories: those whose identity will never be known to the child, and those, referred to as Identity Release Donors (I.D. Release) or “open” donors, who have agreed that when the child turns 18 they can be offered both identifying and non-identifying information about the donor. Those who decide on the anonymous route, either completely anonymous or I.D. Release, must select a donor from sperm bank catalogues that provide increasingly more detailed information about a donor’s medical and social history, education, work history, interests, hobbies, and motivations. Donor selection, though not the focus of this project, is a complex process, layered with assumptions that rely on the nature/culture divide, and on assumptions about the significance of biology, blood, and shared substance. Mamo (2007) and Pelka (2009), among others, recognize the complexities of these decisions and the ways that, despite the emphasis on love and “chosen family,” queer women continue to rely on discourses of genetics and biology in decision making about sperm donors.

While the 1980s and ‘90s, which marked the beginning of what has come to be called the “lesbian baby boom,” were characterized by a DIY approach to insemination influenced by feminism, the women’s health movement, and lack of access to clinics, recent years have seen a turn toward medicalization and increased use of fertility clinics by queer and trans people. In part, people are discouraged from using known sperm donors and home insemination by a number of factors. These include the social and legal vulnerability of non-biological parent(s); the legal ambiguity of the known sperm donor; the challenge that home insemination poses to institutionalized medicine; awkwardness with the intimacies of known sperm donation; legal and administrative barriers such as those embedded in the Canadian semen regulations (Food and Drugs Act, 1996), and the lack of social intelligibility of the known sperm donor.

Barriers to the Use of Known Sperm Donors

As chapter 2 discusses, queer women (and other LGBTQ parents) who do not have a biological connection to their children can experience a particular form of vulnerability. Often at the core of this vulnerability are insecurity and fear about legal recognition. Because fathers have become “good news” in family court (Kelly, 2011, p. 33), queer women planning children are fearful of including known donors in their parenting plans, worried that they will not be sufficiently protected from potential parental claims. Of course many lesbian parents are not interested in including a sperm donor in their family configuration, and as Leckey (2011a) points out, the law and the way it is enacted, has recently resulted in arguments for the “completeness” of the two-parent lesbian family. This works for some lesbian families, but not for others. Leckey argues that legal discourse, policies, and protections can work to both reflect *and* construct the relations they are established to address. In other words, family law and family law reform do not simply reflect pre-existing realities, but also mediate and alter practices. Despite the fact that more than three quarters of the women Kelly (2011) interviewed supported the idea of a child having three or more parents *if that was what the parties had agreed to,*(p. 106), many lesbians, in their preconception decision making, decide against a known donor because there is no intelligible legal category for a known sperm donor who is not a “father.”

Reviewing family law as it applies to lesbian families in Canada, Kelly concludes that

> significant gaps remain: the legal framework is uneven across the country, non-biological mothers continue to be treated as second-class parents or even legal strangers to their children, and the legal status of known donors remains unresolved. (p. 19)

Clearly, the legal ambiguity of the known sperm donor is a significant deterrent to their inclusion and integration in queer women's families.

The use of a known donor is typically coupled with a decision to inseminate at home and outside of medical systems. Haimes and Weiner (2000) suggest that home insemination, or what they call self-insemination (SI), is fundamentally challenging to institutional medicine because it takes place outside a clinical location and does not rely on medical expertise or knowledge. SI is analogous to self-help groups in being a "de-medicalised, de-professionalized social practice which privileges the lay knowledge and concerns of the women themselves" (Kelleher, 1994, as cited in Haimes & Weiner, 2000, p. 496), and does not require compliance to medical authority. To the medical profession, SI means that "the donor and the recipient and the location and the insemination procedures are all unknown, unregulated and (thus) undesirable" (Haimes & Weiner, 2000, p. 496). Tonya describes how the clinic assumed an anonymous donor and was less receptive to the idea of a known donor:

> Tonya: They assumed that we were looking for an anonymous donor right off the top. That was their main assumption. They were walking us through the process of what it would look like to get an anonymous donor. It was very clinical and like they've done it a million times and I'm sure they have done it a million times. And basically the timing and fee schedule that goes along with that. When we did tell them that we already had a donor, you know, they weren't as receptive to that.

Clinics are inconsistent when it comes to support for home insemination. Some will test donors and allow patients to access cycle monitoring in order to determine time of ovulation. Others will have nothing to do with it. The COF interviewees who were using known sperm donors but approached clinics for assistance (e.g., testing or cycle monitoring) were met with inconsistent and unreliable response.

Nordqvist (2011) argues that sperm donation, in a home or clinical setting, raises complex issues of intimacy, privacy, and sexuality. In a home insemination context, lesbian couples negotiate these issues by attempting to establish, sometimes more or less successfully, boundaries that maintain distance between the couple, the donor, and his sexual practice. She suggests that distancing from the donor is achieved through “carefully structured and organized social practices which are meticulously choreographed through patterns of movement and action” (p. 1662), and designed to create separation between the donor, his sperm, and the recipients of the sperm. Several COF participants spoke about the awkwardness of negotiations with donors and the process of home insemination. Antoinette and Donna describe their process like this:

> Antoinette: We could like barely ask him to come over and donate.
>
> Donna: I know. It’s so weird. You know, you’re friends with people ten years, right, then you’re just like, “Could you just…it’s time to…into…the…It’s time, it’s time! Please come over and masturbate in our apartment! Hurry up!”
>
> Antoinette: You know? It’s hard. It’s really hard.

Negotiations are sometimes made more uncomfortable, at least initially, when the donor is also a family member. Jacqueline and Tonya asked Tonya’s brother to be their sperm donor.

> Jacqueline: It was just trial and error you know. He would come down and at first it was horribly awkward because it was not something we ever thought we would do.
>
> Tonya: Oh, gosh you know, oh? It’s just that he’s my brother!... and I’m his sister, you know.
>
> Jacqueline: And he’s handing her a cup and in the beginning it was bizarre.
>
> Tonya: The first three or four times it was just like, oh man, there’s nothing worse than this and he kept saying, “You know, I really hope it works. You guys need to get it together”

Of course none of these dynamics are simple or universal. Some of the COF participants described an initial awkwardness in negotiations with donors, followed by or coupled with an appreciation of the closeness created through the process, including the intimacy of being able to inseminate at home — with or without the donor present. Donna and Antoinette strongly suggest that clinics could reduce the awkwardness of sperm donor/recipient relations by providing recipients and their donors the opportunity to meet with a skilled professional who could facilitate the necessary discussions and negotiations, as well as soliciting medical history and appropriate testing. Of course this would require an acceptance of known sperm donors and home insemination on the part of the fertility industry. Barriers to this acceptance are both administrative and social, embodied in government regulations and in the lack of intelligibility of non-normative kinship relations.

Administrative Blockages: The Canadian Semen Regulations

The Canadian semen regulations, which came into effect in 1996 under the Food and Drugs Act, set out the health and safety requirements for processing and distributing third-party donor semen used or intended for use in assisted conception. The semen regulations define assisted conception as “a reproductive technique performed on a woman for the purpose of conception, using semen from a donor who is not her spouse or sexual partner.” Sperm being used for assisted conception is required to be frozen and quarantined for six months, while the donor must test negatively for HIV and hepatitis at the start and the end of this time period.

Meanwhile, those seeking insemination with the semen of their spouse or sexual partner are excluded from the freezing and sexually transmitted infection (STI) testing requirements. The rationale for this exemption regarding “sexual partners” relates to the risk of contracting STIs. If you are having sex with someone, you are assumed to be already taking the risk of contracting whatever diseases they might have. Insemination with their fresh, unquarantined sperm is not perceived as an additional risk to the health of the person being inseminated.

What this regulation means in practice is that a heterosexual couple, having tried to conceive for a period of time at home through sexual intercourse, can approach a clinic for assistance in getting pregnant and can request insemination with fresh sperm from the male partner. Other individuals and couples (including single, queer female, and trans-masculine people) who have also tried to conceive for a period of time at home through home insemination with a known sperm donor, cannot make the same request. Although sexual intercourse and home insemination entail the same health risk, those using a known sperm donor will be required to have the donor tested, the sperm frozen, and then wait out the six-month quarantine period before beginning inseminations. This involves added medicalization, a hefty financial burden (for testing, freezing, and storage of sperm), a significant time delay, and the use of frozen rather than fresh sperm, which decreases the chances of conception, The semen regulations were unsuccessfully challenged constitutionally in 2007 (Susan Doe v. Canada).

Lying in Waiting Rooms: Frustrations with the Semen Regulations

Here I use the experience of COF participants (or participant couples) to explore the impact of the semen regulations' prohibition of the use of fresh sperm from anyone other than a sexual partner, and the implications of the strategies deployed by LGBTQ people in relation to this prohibition. Normalization strategies, or "inventive pragmatism," such as those that involve deception or lying about sexual relations and identity, can be costly and/or violating to the self. The act of lying about one's sexual orientation and/or family configuration and relationships means not just being misrecognized, as is common in LGBTQ fertility clinic experiences (See Ross et al., 2014) but being asked to *actively participate in one's own misrecognition.* At the root of the struggles that participants describe is the fact that "known sperm donor" is not intelligible as a kinship category within the institutional framework of reproductive services and legislation, or indeed within mainstream social discourses.

Because AHR services are, in general, becoming more open to LGBTQ clients, there are growing expectations among LGBTQ people that they can be assisted by clinics in their reproductive journeys, including assistance with insemination with a known donor. People are often surprised when they discover that there are administrative barriers, or *blockages* to refer back to Ahmed's concept, to receiving assistance. Participants describe the stress and confusion this adds to their experience:

> Jacqueline: We thought it was going to be pretty standard. We thought we were going to go in and tell them what we wanted to do and they'd tell us the process and it would be easy. We figured it was just a money issue that we had to figure out—we were never expecting that we would be told that we weren't able to do that.

• • •

> Lucy: Finding out that there were some barriers to fertility-type services was *really* stressful. Like, highly stressful.

Joe and Charlie summarize their frustrations with the semen regulations and the barriers they encountered in using the known donor of their choice. They express concerns about time delays, financial burden, the use of frozen (versus fresh) sperm, and legal issues:

> Joe: What they were willing to allow was that we could have our donor come up and he could give a sample and they would test it and freeze and test it again six months later and he could keep coming up and giving samples which they would freeze and store at—you know —a substantial cost and then, once the embargo was lifted, they were willing to let us use it but it was going to be a six-month wait, it was going to be using frozen sperm, and it was going to be a crap ton of money.
>
> Charlie: And they would have linked the donor and me on the paper work and seen the donor and me as the parents…
>
> Joe: Which then would have been a further crap ton of money because we would have had to have a second parent adoption and all three of us would have had to have our separate lawyers and la la la.

In addition to these practical barriers, people encounter a policy that seems contradictory and discriminatory:

> Tonya: And I said right there, "Well, hang on a second. People come in here every day to become inseminated with their partner's sperm. Just because we know this guy, he's my brother, he's a family member, he's got to qualify to be a donor? Do you make these people qualify to be donors?" And they said, "Well,

> no, but they're married or they're in a relationship," they didn't even have to be married, they just had to be consenting adults in a relationship. And we were like, "OK, we're consenting adults in a relationship—just not an intimate one, so how does that differ in definition to you?"

Participants point out the contradiction in requiring testing, freezing, and quarantining for sperm from a known donor, when a sexual partner could just as likely be putting them at risk:

> Antoinette: But what makes the husband so trustworthy?! That's what I want to know. The assumption, you know, that relationships between the two are truthful and that no one's lying to each other and, you know, everyone's monogamous.

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> Lucy: As near as I understood it— it was a liability issue for a medical doctor, or clinician, or whoever it would be, to do an insemination with a known donor, who hadn't had the sperm banked and frozen for something like six months… which seemed like a funny double-standard when really, you could go to any old bar on Saturday night and be like "Okay, I'm going to sleep with this person." Versus, you know, our plan was we asked our friend to have STI tests done. And he did.

People also challenged the concept of "risk," suggesting that the risk of choosing a donor from a sperm bank catalogue—choosing someone one does not know based on a list of characteristics and reported history—is perhaps greater than the risks involved in using a donor who is known.

> Clare: It [using an anonymous donor] feels like more risk to me… you know, this person I know and care about and have chosen to be my kid's father... I mean you have to have a lot of respect for someone to ask them to be the biological father of your child. It's like, that is a huge thing. And so, psychologically and emotionally it feels less risky to me to go with a known donor than some anonymous guy that, you know, who knows why they donated sperm? Like… probably for the most part it's for good reasons. But, you know**,** it just felt more risky.

Some AHR practitioners and others working in the field recognize the semen regulations' discriminatory nature and collaborate with patients to find ways to circumvent the restrictions. In most instances, this meant practitioners or clinic staff suggested that people misrepresent identity(ies) and/or family configurations. Interviewees reported that they had been advised by receptionists, students, and doctors to lie in order to access service. While nobody in the sample *did* present as a threesome and only one person (Dan) actually presented his donor as a "sexual partner," participants' contemplation of these strategies, as well as their decisions *not* to deploy them, can throw light on the potential costs of having to lie and collaborate in one's own misrecognition in order to access a desired service.

Inventive Pragmatism / Normative Resistance

Carla Pfeffer explores the strategies that couples composed of trans men and cisgender women deployed in negotiating institutional contexts (2012, pp. 574-602). She suggests that at times these couples can and do choose to manipulate existing social structures to their benefit, while at other times they might actively resist normative structures and assumptions. She uses the analytic constructs "normative resistance" and "inventive pragmatism" to explain such choices:

> *Normative resistance*: conscious and active strategies and actions for making life choices *distinct* from those considered most socially expected, celebrated, and sanctioned;
>
> *Inventive pragmatism:* active strategies and actions that might be considered clever manipulation of an existing social structure in order to access social and material resources on behalf of oneself or one's family. (Pfeffer, 2012, 578)

"Normative resistance" might include resisting traditional marriage, parenthood, and monogamy, and insisting on being visibly "queer." "Inventive pragmatism," in contrast, involves what one might call instrumental work-arounds, such as choosing to access marriage and legal parenthood when these can benefit oneself or one's family. For Pfeffer inventive pragmatism is a process in which people make use of identified weaknesses and/or fissures in institutional power in order to derive social or economic benefits. One might argue that the decision to misrepresent one's sexual orientation, gender identity, or family configuration in the fertility clinic is an example of inventive pragmatism, the identification of a way through a barrier, a work-around that involves "manipulation of an existing social structure." I wonder at what cost? What are the consequences of actively participating in one's own misrecognition?

To lie or not to lie, that is the question.

People's emotional responses to being advised to lie by presenting their sperm donor as a sexual partner are complex and multilayered, and include surprise, relief, gratitude, worry, anxiety, fear, discomfort, and, often, anger.

> Jacqueline: The medical professional left the room—I can't remember what they were doing. They left and there was only a student in the room with us and she said, "Well, if I were you I would just come back with your donor and pretend that you're a couple and there'd be no issue and you'd get it done."
>
> Tonya: I just looked at her as if she had two heads.

Clare called all the reproductive clinics she could find on line and asked about using a known donor. All of them except one said "We just can't do that or "We just don't do that," until someone from a clinic in a major Ontario city made a suggestion:

> Clare: [She said] "Oh yes. There's a legal issue. We can't do that but just come in and tell us he's your sexual partner." Whoever answered the phone told me that. She was super-kind and really nice. And was like, "Oh yes… well, I'll tell you a secret," kind of thing, you know?
>
> I wasn't feeling like, "I can't believe that you're telling us to lie!" I was feeling like "Thank you, for, you know, telling me how this works."

Charlie and Joe received similar coaching on how they could circumvent the semen regulations, in their case from a doctor.

> Joe: Our meeting with the doctor was also very friendly and warm and I really got the sense that he was familiar with the Human Reproduction Act and how it is often unfair to queer couples. So he said things like, "if you have a known donor, we are willing to do cycle monitoring here, send you home with sample jars and syringes. We'll give you a bag of those things. If that doesn't work for you and you're looking at inseminating here, you just need to tell me you're

> sexually active with the donor as well as with your spouse and we can do that here." Like it really felt like he got it and was willing to work with us.
>
> Charlie: And [he] cheerfully suggested that threesomes (his language), were, you know, a common way for people with no sperm in their relationships to get pregnant. So even that conversation felt like, "We know what the law says; he knows what the law says; we'll be able to dance around the law in terms of what we need, in terms of our language here and, let's get going." And to go home with a bag of sample jars and large size syringes also felt like OK, they really are going to help as far as they can help us without legally putting us or them at risk.

Although most people express some form of gratitude or relief at being offered a potential way through the barrier of the semen regulations, they often also describe anger. Participants identify different sources of this anger. For instance, Tonya described feeling angry at the assumption that she would put her partner's health at risk, in addition to anger at the institutional barriers they faced as a queer couple:

> Tonya: I was angry. First of all I was upset that we had to go through some different kind of process than a couple that's in a consensual relationship. In this case it's the same thing, *you have a consensual relationship.* If you think that I'm going to let my partner put sperm in her body that hasn't been tested for STDs, you're wrong. Like, no way. And he (the donor) wouldn't either! You know. And those kinds of test are covered by OHIP, you can get them done and we did, for our own purposes, they were done.

Clare also expressed anger at being put in a position where she was asked to lie about her queer identity after many years of being out:

> Clare: Angry that we had to lie again, you know? I spent a couple of years of my life lying already about who I was, and, you know, I hadn't been there in over ten...twelve years...I don't want to be lying anymore. Why do we have to lie? So I was angry about that. But also, you know, thankful for this woman and that there was an option. But…yeah, I was angry.

Participants also articulated anxiety, worry, and ethical concerns about lying on an official medical record. They worry about the implications for the donor, as well as for themselves.

> Clare: I felt relieved, like, we finally figured this out. It took a long time. But I also felt like I'm not sure I can do that. I'm not sure I can walk in there. What

> kind of implications does this have for him and his family...if he lies on a medical record and says he's our sexual partner? …even though his partner *knew*, we didn't feel comfortable with that scenario. But pleased to have found it out.

In general, LGBTQ people are concerned about what it means to misrepresent who the intended parents are on an official record. Again, this occurs in the context of historical vulnerability and present-day concerns about parental recognition for LGBTQ people.

> Jacqueline: We don't want that anywhere on record that we're coming in pretending that… you know what I mean? Like even legally we would never want that to be on record that he would be the parent or anything, so…

The vulnerability of the non-biological parent is particularly salient when the donor's name, and not hers/his, is put on the record. Tonya described the legal vulnerability she experiences as the non-biological parent and, ultimately, the fear that she could lose her child.

> Tonya: I'm not going to lie about my relationship to my child, you know what I mean? For me to be put on record as ever lying in order to do something for my benefit, it's just not who I am. And…so if it came to a point where something fell through with my brother, for example, having an example of a point in time where I lie doesn't work in my best interest and I'm not willing to lose my children over it, so that's where that sits. I was worried legally, I didn't want that.

Dan described his "husband" (i.e., donor) being asked to sign forms giving him the right to decide, in the case of Dan's death, what would happen to any existing embryos. Having his partner's name on the medical record caused problems when it came time to inseminate:

> Dan: At one point it went badly...my chart had my real-life partner's name on it, which was not the source of the sperm. And the sperm lab looked at the sticker and said "This is no good. You must need quarantined sperm. There's been a mistake." And so we were saying "No, there's no mistake. We're inseminating today, I'm ovulating today. This is our first time. We're doing it today." And they said, "No, no, no there's a problem. We can't proceed." So that was bad. My partner took care of it and I thought, "Oh, it's just a misunderstanding, it'll be fine." I don't think I really realized that they could've just said "No. This is against the rules, this is not the procedure. I'm not endangering my own lab-tech license or whatever is on the line, I'm not going to do it."

As a result of this near miss, Dan and his partner removed the partner's name from the medical record with the result that his partner's name is completely absent as an intended parent:

> Dan: I think we peeled the sticker off because it was just too complicated. It was sad, because it was nice to have his name there. Because it felt good...because he *is* my partner and this *is* our child that we're trying to make together.

Dan experienced the exclusion of his partner through his erasure on the medical record.

Clare, the non-genetic, intended parent with her partner Lucy, described an additional, and significant, implication of presenting their donor as Lucy's sexual partner. Clare would be left out of the conception process itself.

> Clare: My role, as the other mom, would be not to go. I couldn't... I wouldn't show up. I remember talking to you [Lucy] about how I would feel about that…in the end, you know, sure I'd like to be there. But maybe in the end, you would just do it. I remember feeling kind of angry. But relieved. But confused. I don't…I don't know…And feeling excluded. I remember— actually I *did*, remember I *did* feel excluded?
>
> Lucy: You did at the beginning. Now you don't because there's just so many dirty diapers...there's more than enough of everything to go around.
>
> Clare: I did feel excluded. That's right...I'd forgot. I did feel excluded from it. And that was a concern that I had at the time...was feeling part of it…the whole thing — part of creating a family and...you know. Yeah. I didn't have any legal worries. Like, that wasn't it. It was more on an emotional level…not wanting to feel excluded.

Dan is the only person we interviewed who actually misrepresented his donor as a sexual partner in the clinic. He talked about how it feels to participate in a process in which he was so dramatically misrecognized. Although he identifies as a trans man and is partnered with another trans man, in the clinic he presented as a heterosexual woman with a cisgender male sexual partner who is providing sperm. However, while the clinic assumed he *is* a woman, at times they also assumed he is a lesbian, and that he was using an anonymous sperm donor. So a gay trans man, pretending to be a cisgender heterosexual woman, was misread as a lesbian. His gender identity, sexual orientation, and route to parenthood were distorted and misconstrued, and his partner was left out of the process.

> Dan: And the doctor would be saying “Oh, well, father’s sample at this time. Don’t worry, we’ll take care of the timing.” And I’d say “No, I’m talking about a person. It’s not a…a sample.” And then I’d get all uptight. How do I talk about, like… “I mean my husband, I mean my boyfriend.” I didn’t know what to say but there were a couple of times that I burst out laughing because it was clear that he was *assuming* that I was a lesbian and I was thawing out a sperm sample. And I didn’t know how to say without myself getting in trouble, “No, he’s...a...a live person coming to the clinic and ejaculating in a cup.” So there were moments where I panicked that I’ve said the wrong thing, but for the most part I forgot…I blocked it out.

Another consequence of Dan’s “deception” in the clinic was that he hesitated to complain about unsatisfactory treatment he got from the doctor because he was grateful that he was being allowed to use the donor of his choice:

> We [the doctor and he] were not a good fit. And I’m stubborn and I didn’t want to make changes. Partly because I was so grateful that she was letting me use my known donor and pretending he was my partner…I put up with it for a long time.

Finally, although he describes often “blocking out” the fact that he was lying, Dan articulated his underlying fears and anxieties about the potential consequences of lying:

> Dan: The doctor did explain that this person would be my partner in the clinic. That on my records he’s my partner. On my chart, he’s my partner. When I speak of him to the other staff I refer to him as my partner. I think at the moment she said it, it all seemed kind of heavy and serious and I worried “What if I slip up?” but I definitely completely forgot for most of the time I was at the clinic because I used inappropriate language and I was reminded a few times “Who’s the partner and who’s the supportive friend?” And then I thought “Are the police going to come? Is the Ministry of Labour going to investigate me, the Ministry of Health going to investigate me? How serious is it if I say the wrong thing?”

Lying as Violation

If ethicality, as Thompson suggests, can be evaluated by ruptures or violations to personhood, these narratives are rife with such violations (Thompson, 2005, pp. 179-204. Consider being put in a position of having to actively collaborate in the misrepresentation and misrecognition of one’s sexual orientation, gender identity, and/or family configuration; being potentially perceived as an irresponsible or “bad partner” by putting one’s partner’s health at risk; being forced to (re)hide an aspect of one’s identity that has been historically challenging to disclose; having one’s partner administratively erased from an official medical record and having instead an inaccurate record that potentially gives significant decision-making power to someone who should not have it. What is it like to have one’s partner or co-parent left out of the process of conceiving a child that you intend to parent together? To be reluctant to advocate for good health care because one is feeling grateful for having access at all? To experience underlying fears and anxiety about the implications of all of these situations, including, whether based in reality or not, the fear that one’s child will be taken away. All of these practices constitute violations or ruptures to personhood.

The participants included here were offered two options: the option of presenting one’s sperm donor as a sexual partner, and the option of presenting themselves and the sperm donor as a threesome. While both strategies fit Pfeffer’s definition of inventive pragmatism, that is, “making use of identified weaknesses and/or fissures in institutional power in order to derive social and material resources on behalf of oneself or one’s family,” presenting a donor as a sexual partner and representing oneself as heterosexual deploys conventional social structures and assumptions, while presenting as a threesome that includes the donor overlaps with what Pfeffer calls “normative resistance.” In other words, the “threesome” option can be a choice to present as a family configuration “distinct from those considered most socially accepted, celebrated and sanctioned” (Pfeffer, 2012, p. 578). This hybrid strategy does not necessitate the denial of sexual or gender identities, nor does it exclude an intended parent from the conception process (as the “sexual partner” scenario often does). But, unless it actually reflects reality, presenting as a threesome still involves a deception or a misrepresentation.

In both scenarios of misrepresentation, LGBTQ people might find themselves on “shaky legal ground” with potentially “frightening and destabilizing consequences” (Pfeffer, 2012, p. 594) should anyone be externally challenged after having pragmatically made use of institutional conventions —when, for example, donors are put on medical records as intended parents. Dan described how “it went badly” when his real-life partner’s name was on the file; Clare and Tonya described their fears of the implications of lying on an official record, including their fears of somehow losing their children. Central to these fears is the fact that only certain kinship relations are legally, socially, and institutionally recognized and supported.

The Relationship That Has No Name

The decision to conceive by way of a known sperm donor is complex. For some LGBTQ people, the decision is purely economical, in that the costs of accessing AHR services and donor sperm are prohibitive. Others grapple with the relational and emotional implications of using an anonymous donor:

> Dan: I definitely wanted somebody who could answer questions when my kid said “Why do I look like this? How did I come to be? Why was he donating his sperm?” I very much wanted to say, “There he is, go ask him! Here’s his phone number, here’s his e-mail address, go ask him.” I don’t want to speak for him.

Some struggle with the “eugenics” involved in donor selection, with the ways that donors are characterized in sperm catalogues and the complexities of deciding what one is really looking for in a donor and how this can be “measured”:

> Lucy: And it was a really weird sense of being, like, “Oh now we have to choose, like, from a group of men who have chosen to donate sperm...which is great...but it’s like…I just felt, what a bizarre way to make a choice…actually I don’t know what it’s like. I’m assuming it’s a catalogue like you see on TV.

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> Charlie: And I would say for me the eugenics side of it felt kind of gross, and it’s not that you don’t pick a partner for qualities you like—you certainly do

> pick a partner for qualities you like —but you don't have the same sort of totally theoretical, totally abstract, no real human being in the room sort of weighing of what are my absolute priorities about a person? How do I quantify that and compare them? As we talked about it, we eventually came down to, we would like a donor that is smart and kind and that those felt like the values we really wanted. And "kind" isn't represented in those catalogues.

Those who have been historically mistreated by institutionalized medicine might steer away from extensive medical involvement in the conception process. Additionally many recognize the fertility advantages of "fresh sperm" and a DIY approach.

> Joe: We sort of thought, let's see if we can go with the formula that we know has a high likelihood of success. Fresh sperm, you know really fresh, like thanks for the cup, see you in ten minutes. And I think also as trans people who have been in a lot of ways kind of at the mercy of the medical system, staying away from it to whatever degree possible felt like a good idea.

While the use of an anonymous donor assumes and guarantees no involvement of the donor in the child's life or the parenting process, the use of a known donor can involve an enormous range of involvement, from absolutely none to full integration as a caregiver or parent. The negotiated, flexible, and sometimes ambiguous relations that a known sperm donor might have, both with a child and with the child's parents or primary caregivers, make this a kinship configuration that lies outside of convention and, most often, outside of language. Susan Goldberg describes struggling with what to call a sperm donor and how to render a family of more than two people as parental (or something else) units, intelligible to others: "Is Rob a father? A dad? An uncle? A parent? A very good friend? Something in between all of these? Is it that we don't know, or that language fails us when it comes to the words to describe our relationship?" (Goldberg, 2010, p. 29). Sometimes donors are "dads," sometimes they are not, and sometimes they are something in between: "Chip was more than a sperm donor, but less than a daddy" (Goldberg, 2010, p. 21).

Robert Leckey attempts to summarize what this looks like in practice:

> Donors may be known or involved without being considered to be “fathers” or co-parents with the mothers. Some lesbians prefer that their child’s donor be seen not as a “father” or a “parent” but, rather, as an “uncle” who will not take part in decision making…Conversely, referring to the donor as a “father” need not imply involvement. (Leckey, 2011b, p. 596).

Fiona Kelly divides donors into three categories:

- A “flexibly defined male figure” with whom their children have a relationship but to whom no parental status is imputed
- Donors as symbolic “fathers” with almost no relationship with their progeny
- Donor as an active, practicing parent with all the rights and responsibilities implied by that status, though without legal custody. (Kelly, 2011, p. 102)

What becomes clear in this discussion is that, within North American kinship discourse, the known sperm donor is a largely unintelligible category. How does one conceive of a person who is in some cases a father, in some cases not a father, sometimes sort of a father, sometimes like an uncle, and sometimes a complete stranger? Perhaps the known sperm donor is a hybrid kinship category that exists as what Butler (2004) might call “the not-yet-subject and the nearly recognizable.”

> Indeed, there are middle regions, hybrid regions of legitimacy and illegitimacy that have no clear names, and where nomination itself falls into a crisis produced by the variable, sometimes violent boundaries of legitimating practices that come into uneasy and sometimes conflictual contact with one another. These are not precisely places where one can choose to hang out, subject positions one might opt to occupy. These are nonplaces in which one finds oneself in spite of oneself; indeed, these are nonplaces where recognition, including self-recognition, proves precarious if not elusive, in spite of one’s best efforts to be a subject in some recognizable sense… the claim of the not-yet-subject and the nearly recognizable. (Butler, 2004, p. 108)

When we asked the COF participants who had involved a known sperm donor in their procreative planning what kind of changes they would like to see in the AHR system, a primary concern was the desire to have their ties with their known donor recognized *as a relationship.* People framed their discontent within a framework of discrimination, equity, rights, and/or choice. Many perceive the root of the problem lying in the lack of recognition of the known donor and the consensual *relationship* that is involved:

> Tonya: In the case of known donors they need to acknowledge that…*having a known donor is a relationship.* They need to understand that the people who are establishing that relationship are in a consensual relationship and that they are taking the risks that are inherent in having a relationship because of that consent.
>
> • • •
>
> Dan: Straight people choose their partners and have kids and queer people should be able to choose their partners…donors...source of donor-egg…whatever…and accept the risk of what they're doing.
>
> • • •
>
> Clare: I feel like I have a right to decide who is going to be the father of my child. And it seems completely absurd to me that you're denying me that right. And I do understand that it's for a good reason. But I think there needs to be a loophole here. And I always kept thinking to myself "Why can't we just sign a waiver? ...you know...we did an STI check. Why can't we show you that paper with the date that was yesterday and sign a waiver so that you're no longer liable? And it's our choice. Is this not our choice? Like, this should be our choice, you know? … Everyone else seems to have this right. It just seems crazy to me…we should be able to sign something. So…that's what I would say to the minister: Create a form. Find some lawyers. Figure this out.

Recognizing LGBTQ People in AHR Services: A Two-Step Process

In Chapter 3 I suggested that LGBTQ people might benefit from "more" objectification in the fertility clinic. I pointed out how Thompson's idea of "agency through objectification" — an objectification than can enhance subjectivity when it remains attached to the goals of the long-term self — often fails when LGBTQ bodies and kinship configurations are involved because practitioners are unable to separate these strange or unfamiliar bodies, identities, and kinship structures from the body parts and gametes involved. Nina says it would have been good if she could have been treated "just like a uterus," instead of as a uterus with a particular kind of woman attached to it. I suggested that a first step in this process is a dismantling of the assumptions of the heterosexual matrix, the assumptions that gendered body parts (ovaries, uterus, testicles, penis) that produce gendered gametes (sperm, eggs) are tied to sexed bodies (male/female) with binary gender identities (man/woman), normative gender expression (femininity/masculinity), normative sexual orientation (heterosexual), and normative sexual practice (heterosexual intercourse — which is called “sex”). Reproductive technologies, by separating conjugal sex from reproduction, and by differentiating genetic, biological, and social parenthood, create the conditions for dismantling these assumptions. Through the technologies it becomes possible to disentangle the heteronormative assumptions detailed here, a disentangling that potentially serves LGBTQ users of AHR services.

However, the narratives from COF participants in this chapter suggest that the dismantling of these assumptions does not adequately or fully address the concerns of LGBTQ people. Once the assumptive links of the heterosexual matrix have been disentangled or separated, a second step involves putting things back together in a way that recognizes LGBTQ kinship relations.

People need space to define their identities and to create narratives of their reproductive long-term selves, separate from the heteronormative assumptions currently embedded in clinic practice. As the examples illustrate, heteronormative clinic practices administratively erase parenthood for a lesbian intended parent doing IVF with her partner (when the identical heterosexual parent *is* recognized), and refuse to recognize known sperm donors as relations of kinship. Clinic and sperm bank practices currently serve to separate the sperm donor from his gametes, a separation that assists the negotiation of the intimacies of sperm donation (Nordqvist, 2011, pp. 1661-68). The need for this separation, however, is mediated by the heteronormative assumption that sperm = father. Sperm donation requires then, that this relation be severed and that the donor and their sperm be viewed as more “object” than person. However, the people quoted in this chapter, all of whom chose known sperm donors, *want recognition of the relationship* with their donor, in most cases *not* as father, but as something else.

In a broader sense, the LGBTB participants in this study are asking for the space to define their own families and kinship relations, in all their complexities and hybrid forms, and outside of a model that assumes “mom and dad.” The dismantling and reconstituting of the heterosexual matrix’s pieces might be conceptualized as taking apart and putting back together the pieces of a puzzle. However, the puzzle can be reassembled in a multitude of ways. LGBTQ people (and others) who are making use of AHR services to have children, require legal, social, and linguistic space to allow them to assemble their particular puzzles in the pattern and involving the body parts, gametes, identities, and kinship relations they choose.

Chapter 5. Towards a Queer Ethics of Care

> I think I would say to them [AHR services] that they need to get their shit together around understanding the diversity of people that walk through their doors…It's their responsibility and so they really need to listen and hear it and make changes…It's as if they're not comfortable with it and I don't understand that. (Rebecca, COF participant)

The previous two chapters explored the blockages that LGBTQ people encounter in their interactions with fertility clinics and how LGBTQ identities and kinship structures are often misrecognized and, in many cases, unintelligible in the clinic context. The assumptions of the heterosexual matrix, in alliance with the culture of the fertility clinic, can result in violations or ruptures to the personhood of queer and trans people as they attempt to make their way through the clinic. Furthermore, the strategies that people adopt to enhance their flow through the clinic at times contribute to their own violation. I suggested that LGBTQ people might benefit, counterintuitively, from *more* objectification — from the separation of identities from body parts and gametes, followed by a second step that allows people to assemble their kinship and family narratives as they choose.

This final chapter explores the possibility of a more ethical relation between fertility clinics and LGBTQ people, some institutional barriers to such a relation, and pedagogical questions related to educating medical practitioners to bring reflexivity, and change, to their professional practice. I explore both clinic practices and pedagogical work designed to improve clinic practices, interrogating, in each case, the usefulness of approaches based on "sameness" or empathy in creating conditions for openings to "alterity." I conclude by raising some pedagogical questions related to diversity work in professional settings.

Ethics and the Other

Thompson suggests that medical procedures, technologies, and practices might be ethically evaluated based on whether patients experience them as strategies in service of the long-term self and thus as agency enhancing, or whether they are in some way rupturing of personhood or subjectivity, and therefore depriving of agency (Thompson, 2005, p. 201). Todd (2003), drawing on the work of Emmanuel Levinas, argues that ethicality in relation to the Other lies in recognizing the radical alterity of the Other. The lack of this recognition, which often manifests in a desire to make the Other into something familiar and "just like" the Self, is necessarily violating of personhood, and therefore, fundamentally, not rooted in ethics. An ethical relation to the Other, according to this line of thought, is grounded in a refusal to reduce the Other to the Self.

I find it helpful to view the clinic's confrontation with the Other, by way of LGBTQ bodies, identities, and kinship structures, as an example of Self meeting Other, a meeting which can be disruptive and destablilizing to self-identity. As Todd puts it,

> The Other is that which disrupts its coherency, the subject tumbles into uncertainty, its past strategies for living challenged by the very strangeness of difference itself…one risks altering the very parameters of self-perception and one's place in the world, and risks losing, therefore, one's bearings and conventions (2003, p. 11).

Taylor (2009) concurs that a confrontation with the Other can be profoundly destabilizing. In a piece about religious homophobia in the classroom, she suggests that when students who are strongly identified as religious followers are challenged in their homophobia, they can experience this as a crisis of identity, the challenge to their homophobia conflicting with deeply held discursive investments. She argues that, for those with deeply held homophobic views, the challenge to these views can amount to an internal cultural conflict that calls into question "key discoursal structures of identity — what one needs to believe and who one needs to be." While the “gut-level disgust” people may experience is, in fact, a product of “powerful socially constructed discourses such as medicine, law, capitalism, and religion” (p. 227), it can be also experienced as a deep internal conflict with the Self. While Taylor uses a primarily sociological framework, Todd draws on a psychoanalytic one, framing the encounter with what is outside the subject as a kind of trauma that threatens the stability of the ego (Todd, 2003, p. 10). In both cases, the encounter with the Other can destabilize deeply held discursive and affective investments. The Other creates discomfort and dis-ease and, Todd suggests, we respond to the riskiness of the encounter with “dynamics of affect mobilized in order to…define against, identify with, or disavow the Other” (2003, p. 11).

One of the Self’s strategies, when threatened by an encounter with the Other, is to incorporate the Other into itself, to make the Other “just like” the Self, “just like” what is familiar and known. This desire to make the Other into something familiar characterizes much of what might be called the assimilationist focus of recent struggles by LGBTQ people for equal rights and recognition, a focus that assumes a “just like you” framework and sees liberation in the establishment of rights for LGBTQ people equivalent to those enjoyed by cissexual, heterosexual people. A similar framework has characterized queer parenting struggles for recognition, with much queer parenting discourse focused on how the children turn out “the same as” children growing up in heterosexual families (Epstein, 2009, p. 15). Queer parents, in this discourse, are represented as “the same as” other white, middle-class, heterosexual couples who, of course, desire babies. Take, for example, the language from a 2003 *Globe and Mail* weekend edition, which featured a front-page photograph of a gay man holding a new-born baby, accompanied by a two-page spread on gay men becoming fathers. The article describes and quotes some of the men who are considering parenthood:

> None fits the stereotype of the flamboyant drag queen or promiscuous, muscle-bound, bar-hopping gadabout… the pair are the image of domestic bliss, as traditional as a couple can be… they met, fell in love, proposed marriage on bended knee, wear wedding bands on their fingers, bought a house on a leafy street in west-end Toronto and now want to settle down and start a family. "I can't tell you how normal we are. Not all gay people are on Church Street wearing leather in the parade. We're in bed at 10:15 after watching the news, and we go right to sleep. We do everything that other couples do. So why wouldn't we want to have a child? (Philp, 2003, pp. F4-F5)

As I have noted elsewhere (Epstein, 2005), while anyone who is a parent understands the exhaustion that comes with parenting and the need to go to bed early, this quote is disturbing for a number of reasons: it disavows certain segments of queer communities (the drag queens, promiscuous, and gadabouts), it desexualizes the men involved (they go right to sleep), and it brings gay parents into a discourse that is profoundly normalizing (the proposal, wedding bands, house on a leafy street, all in the name of domestic bliss). This discourse recognizes gay families that resemble the fantasy of the heterosexual nuclear family (a nonexistent norm that continues to plague gay and straight alike) and delegitimizes those who look otherwise (one-, three- or four-parent families, families with involved donors, parents who don't own houses or who don't live together, people who co-parent outside of sexual relationships, trans parents, polyamorous parents, even parents who have sex before going to sleep).

Of course neither the development nor the critique of these normalizing discourses is simple. In the case of queer parenting, for example, arguments that queer parents are "the same as" straight parents were necessitated by the court cases of the 1970s and '80s in which lesbians and gay men stood to lose custody of their children. It is questionable whether arguing for a plurality of family forms and sexual and gender identities at this time would have served anyone well (except perhaps the homophobic spouses fighting for custody). Although in Canada the struggle for same-sex marriage had virtually no impact on parenting rights (the two are separate in

Canadian law), in the United States marriage rights and parenting rights are often intertwined and there can be clear economic benefits to being married.

However, it is instructive to recognize the limits of "just like you" arguments. In the political and social arena, the strategy of achieving equality for LGBTQ people through assimilation and sameness can lead to a narrowing, instead of a broadening, of possible sexual and gender identities and behaviours — a restriction of what is intelligible and recognizable. In the arena of ethics, the insistence on the search for "common ground" and recognition of the Other through familiar and self-referential models, some would argue, is a violation of the Other's personhood. By assuming comprehension of the Other by reducing them to what is like ourselves, we potentially limit our ability to allow, and be open to, their alterity. Such are the potential risks of an exclusive focus on *empathy,* a concept central to most pedagogical efforts to improve communication, including service-provider training, and often a key element in social justice education.

A Discomfiting Other in the Clinic

Gender dynamics in clinics are framed by the deeply constraining historicity of heterosexual hegemony. LGBTQ people, when they enter AHR spaces, are a discomfiting Other. The COF interviewees provide multiple examples of the heterosexual hegemony prevalent in clinic culture and of how LGBTQ people are offered inappropriate treatment because their bodies and kinship relations do not fit the cisgender heterosexual infertility framework of the clinics.

Sam and Rob, two trans men planning a baby together, are told to "have sex today, have sex tomorrow, have sex the day after, and then come back to see us." Rob is subjected to blood tests, even though he will have no biological or genetic connection to the child they are conceiving. Sam is consistently called by the wrong name and assumed to be a cisgender woman. Stacey and

Nina, a trans woman and her cisgender female partner, are interpellated into the clinic as "a straight couple with male factor infertility," and Stacey feels that her transsexuality gets in the way of her being perceived as a lesbian, and that she is not recognized as a mother. Nina is subjected to multiple fertility tests, many of which she finds invasive and unnecessary. Stacey is congratulated on "the boys," while Nina is a "good girl" when she ovulates. Andrea, a trans woman, is handed a form that asks if she is "married, single, or gay" and given pornography that does not match her sexual interests. Karleen, a butch dyke trying to get pregnant, feels like a gender outsider in the clinic, and she and her partner Hilary are asked about ejaculation and intercourse. It is assumed that if you have a uterus, you want to use it, that is, women who have no desire to get or be pregnant are assumed to be open to this possibility if, for example, it proves not possible for their female partners. Women planning babies without the involvement of men are asked about "male role models," known donors are unrecognized as significant, but usually non-parental, kinship relations, and anxiety circulates around questions of paternity and the need for a father.

In response to the destabilizing and unsettling confrontation with the strangeness of the Other, clinic practices work to incorporate LGBTQ people into an existing framework, into that which is familiar. Joe and Charlie, two trans men introduced in chapter 4, describe what they call the "normalization theatre" they unintentionally perform in the clinic and with the birth registration office:

> Charlie: And it's interesting, I feel like the phlebotomist's response to us was that we always showed up together, we were always clearly sweet on each other and tender with each other and she really likes couples who really want to be parents and who like each other become parents.
>
> And interestingly, she [birth registration administrator] called as Baby and I were heading out in the car for whatever reason and we said "Hang on a sec," and she sort of had to listen to us get the baby ready and sort of work through things and really sound like a normal, normal family with a new baby doing

> things that families with new babies do, like “Do you have the diaper bag and new hat?” and you know “Can you carry the bucket out to the car?” because I had a C section? and like all of that stuff, so by the time we got to telling her the story she’d already had this, “Oh you really are a family, doing family things, with a baby that I can hear in the background.” And we hadn’t intended that as sort of normalization theatre.

While they are grateful for the treatment they receive in both these instances, they understand the good will being sent their way as predicated on their presentation as a normative, happy couple who are sweet on each other and want to spread the love by becoming parents, and then as a typical and normal couple with a newborn, in both cases something familiar and recognizable to those in charge. In other words, an empathic response.

While I would not argue (and probably neither would they) that this is a negative outcome for these two guys, particularly given the extent and depth of transphobia typically encountered in health care and government offices, it is disquieting to think that the prerequisite for LGBTQ people to be treated well in these settings is a performance of cis and heteronormativity. Joe and Charlie describe such interactions as “normalization theatre,” implying that their recognition and good treatment in the clinic and at the birth registration office depends on their performance as a normal, happy couple and typical new parents, “just like” the familiar heterosexual couples that are the configured users of AHR services. Of course not all heterosexual couples are happy, nor is new parenthood always sweet, and it could be argued that heterosexual couples also perform in the AHR setting, however there is a particular quality to the violation of being recognized only through a lens of similarity to a dominant norm, and of having one’s identities and experiences that are hugely different from the norm made invisible or ignored. While something works for Joe and Charlie in this scenario, what is missing is the recognition of their alterity, which Todd would argue is the basis of ethicality.

The Limits of Empathy

Todd's book called *Learning from the Other* explores the ethical possibilities in relation to learning from others (2003, p. 3). Central to her discussion is the concept of empathy. Typically described as the act of "putting oneself in the shoes of the Other," empathy involves the search for common ground, a bringing of the Other into the self, a recognizing of the Other through one's own experience. Empathy is built on the idea that knowledge about the Other is central to changing one's relation to them; social relations can be transformed by acting on the knowledge and understanding one acquires of the Other. If we know more about the Other and come to understand them better, we will treat them more humanely. Todd argues that while of course we *do* empathize with each other, and empathy can "connect us in profound ways" (Todd, 2003, p. 51), empathy can also constitute an act of violence, a refusal of the Other's radical alterity, or strangeness, the recognition of which, according to Levinas, is the basis of true ethicality.

Todd draws on Zygmunt Bauman's analysis of "forms of togetherness," and, in particular, she differentiates between "being with" and "being for" the Other. She suggests that encounters that might be characterized as "being with," such as the ordinary interactions of students and teachers in a classroom, are

> constrained by the parameters of time and place, whereby people may have interesting interactions but are not transformed in any way by them. As a consequence, aspects of the self are negated in ways that are normative and safe… The risk of "losing one's self," so to speak, through interactions and conversation is simply not possible in the modality of being-with. Moreover, concern for the other fails to develop fully (Todd, 2003, p. 47).

Being with is normative and safe and does not involve the threat to self potentially brought on by an encounter with the otherness or "strangeness" of the Other. *Being for*, on the other hand, demands an attentiveness to alterity, to the Other's "uniqueness" in a gesture of responsibility (p. 48). Being for involves a passive openness to the Other, an openness accompanied by vulnerability, susceptibility, and a move away from self-interest to a place of responsibility for the Other. These moments cannot be planned or predicted; rather they are spontaneous and surprising, “a togetherness born out of the immediacy of interaction, a communicative gesture that does not have as its end anything except its own communicativeness” (2003, p. 48). Being-for is a relation to the Other that involves a commitment, but a commitment that cannot be planned or called for, but that arises in interaction.

The call for empathy can be seen as a call for this form of togetherness, a call to break through the conventions of daily life and interactions, to involve people in “transformative emotional experiences, ones that involve their ‘whole’ selves, their entire being” (p. 47), and that lead to greater commitment, concern, and moral responsiveness to people one does not know. However, given the unconventionality and unpredictability of empathic feelings, Todd concludes that the “call for empathy,” is actually an impossibility; empathic feelings cannot be “called for,” or demanded because they are “within no one’s sphere of control” (p. 49). Empathy is spontaneous, unpredictable, and surprising; it cannot be planned for or demanded in a pedagogical setting or elsewhere.

But what about empathic feelings that are not demanded but that arise spontaneously in interactions with others, or in response to depictions or information about the experiences of others? Todd concludes that, although of course empathy plays a role in our emotional lives and that, “of course we do empathize…in ways that are already implicated in profoundly ethical relations where the alterity of the Other is at stake” (2003, p. 63), empathy *is not*, fundamentally, the best starting point for moral concern. Whether one is bringing the Other into the self through identification, or putting the Self into the Other through projection, both involve the search for common ground, the making of the Other into the self. Empathy is often linked to “learning about" the Other, the assumption being that the more we know about the Other, the more we will understand them and the better we will treat them. It becomes a form of applied morality, our moral actions perceived as rooted in knowledge about the Other and a set of ethical principles. Todd differentiates "learning about" from "learning from," the latter implying the kind of interaction I described —an interaction that is about a receptive openness to the Other, a respect for the alterity of the Other, and a commitment to maintaining this alterity. One does not assume one can "know" the Other, but one feels responsible for them outside of knowledge. One recognizes the radical alterity of the Other, refusing to reduce them to a common ground with the self.

It is this tendency to reduce the Other to the Self that is at the root of LGBTQ difficulties with AHR services. Clinic culture is rooted in "fixing" heterosexual infertility and in repairing damaged heterosexual gender. LGBTQ people are brought into, and understood through, this already existing framework of cisgender and heterosexual infertility. While this results in access and better treatment for some, the end result of the attempt to make LGBTQ people "just like" the configured users of AHR services is what I described in chapters 3 and 4 — deep misrecognition and violations of personhood. People are refused the opportunity to represent their own sex, gender, and kinship identities and narratives.

Establishing a conceptual framework and clinical practices that do justice to the array of bodies and family configurations that turn to fertility clinics for assistance involves a significant paradigm shift for clinic staff. In particular, it involves a shift from attempting to incorporate LGBTQ people into clinic protocols in a way that renders them recognizable, that is, like something we already know, as "just like" other AHR patients, to a stance of "not-knowing," a stance that recognizes the alterity and unknowability of the Other and that leaves their strangeness intact, allowing them to define their reproductive projects on their own terms.

Adopting such an approach involves understanding what's at stake in the fertility industry when it encounters LGBTQ bodies and identities. An ethics of care that appropriately meets the needs of LGBTQ fertility clinic clients requires a cultural shift that the fertility industry may or may not be prepared, willing, or able to accomplish. What is at stake for fertility clinics when they're asked to open their doors, hearts, and minds to LGBTQ bodies, bodily fluids, and kinship configurations? What aspects of clinic identity are threatened by this request and how possible might it be, given the context of fertility medicine's culture, to expect a significant shift in stance and, ultimately, in practice?

Doctor Knows Best

In the context of AHR services, doctors hold a particular kind of authority and power. As anyone who has been through the fertility clinic process can attest, the assumption that "doctor knows best" is central to the clinic's culture and it is reinforced by the vulnerability of people dealing with infertility and their desires to have professional knowledge and expertise "fix" the problem. And of course fertility medicine is an example of what Foucault would call bio-power, involving institutional regulation of the norms governing bodies. Within institutionalized medicine, the doctor is god-like, wielding authority, knowledge, and power. In fertility medicine, the doctor holds the key to the knowledge, instruments, and procedures that can lead to pregnancy and/or parenthood; negotiating the clinic environment includes negotiating one's relationship to the doctor. As Thompson describes, part of being the "good patient" is managing one's relationship with the doctor. Civility is critical to appropriate patient comportment; inappropriate behaviour includes arguing with the doctor or with one's partner (Thompson, 2005, p. 91). Thompson describes how female patients flirt with the doctor, male patients bond with the doctor, and everybody works hard to not make the doctor mad. You might recall Sam expressing fear about the doctor yelling at him after having overheard him yell at another couple in the next room.

In fertility medicine the doctors know best, even when they don't, as we heard earlier from Stacey whose doctor gave her medical advice based on inaccurate information about the meds she was taking. Nina sums up her experience of a medical environment in which it is assumed the doctor know what is best for her:

> Nina: It made me really uncomfortable because it's like this medical space and there's doctors with their lab coats and their clip boards, and this gendered ideological framework of this is how people are supposed to proceed through it, right? *This is best for you.*

Rebecca

Rebecca is a COF participant I have not yet introduced. She is a single, bi-racial queer-identified woman, trying to get pregnant at home with a known donor. Her community connections suggest that she see a particular fertility doctor, who despite his "terrible bedside manner, can get you pregnant." Following a negative experience with him, Rebecca goes to another clinic where, instead of feeling shamed and disempowered, she feels angry. Although the doctor is more open and welcoming, Rebecca expresses frustrations with the class elitism of the clinic environment, the unexplained and constantly spiralling fee structures, the lack of information she is offered regarding the drugs she ends up taking, and her struggles with the clinic regarding HIV testing of her donor with whom she is inseminating at home, separate from the clinic. After getting pregnant at home and then miscarrying, she eventually conceives at home for a second time, without the use of drugs or medical intervention.

Rebecca describes her first visit with a fertility doctor, offering a startling and quintessential example of the doctor-knows-best attitude:

> I walked in and I wasn't really wearing the right outfit to be in a mansion, and I remember sitting there on the leather couch, feeling like heat on my face...and then I saw the doctor, and he was just so…like I'm sitting in front of this really arrogant male, you know. He basically sat down and said, "I'm gonna tell you everything about yourself." Like he barely looked at my forms. He glanced at them from the waiting room to his office, and he literally sat there and said, "I can tell you what's wrong with you," because he looked at my size and he assumed I had polycystic ovary syndrome (PCOS). So basically he said, "I know what I need to know about you—I'm going to do some tests to confirm it." And I was sitting there and I felt so disempowered and then he started saying, "Because the thing is, once we confirm this, there's a drug I can give you, and then you'll lose like sixty pounds, and then it will be easier to get pregnant." And all of a sudden I'm thinking, oh my god, I just want to be monitored.
>
> When I went back for the second appointment, he said, "Well, the bad news is you don't have PCOS." I was like, "How is that bad news?" He said, "Well, because the treatment's not going to work"… So he actually came into that appointment with a furrowed brow, like in all seriousness to tell me that it was terrible that I didn't have this syndrome that he could treat so I could get pregnant. And I realized in that moment that I wasn't like a person, I was just like a set of complex possible things, right? And I was really mad. Because I felt like he really didn't treat me like a human. And I was like, "No, that's good news. You've given me good news." And so I never saw him again.

The doctor, in this instance, takes one look at Rebecca and tells her what's wrong with her and how he can fix it. He is eventually proven wrong, but presents it as bad news that she does not have a diagnosis that he can fix. Her description of her visit to the clinic also reveals the links between medical experts, the pharmaceutical industry, and the big business of fertility.

"Frosted Glass and Fees Out the Ass" [1]

Laura Mamo, in a follow-up to her 2007 book, reminds us that Fertility Inc. is a multi-billion-dollar-a-year business, "globally comprised of free-standing and medical center fertility clinics: mostly private sperm and egg banks, surrogate broker services, medical specialties, 'donors'

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[1] The title of this section comes from one of Rebecca's descriptions of a clinic.

selling their eggs and sperm, and a growing population of consumers seeking services" (2013, p. 229). She suggests that the increase in access to AHR services by LGBTQ people results primarily from the need to increase profits:

> Given the big business of fertility, strong competition exists for consumers among doctors, clinics, and gamete banks. Yet, the consumer base, while slightly varied and increasing, has not been very elastic. To increase profits, these services need to offer additional services, increase "unit" costs, or establish new markets. Such expansions are well underway, and queer users constitute a part of this market.

LGBTQ people have been "let in" to AHR services, in part, as a new source of patients, and therefore, profit. However, despite increasing access by LGBTQ people, heterosexual couples who are having difficulty conceiving continue to be the majority of fertility clinic clientele. An IVF procedure (used by the majority of heterosexual couples in a clinic setting) is far more costly, and therefore profit-making, than simple donor insemination (more typically used by queer and trans people). Clinics compete for business based on statistical success rates (Thompson, 2005, p. 104), typically measured in successful IVF pregnancies. Queer and trans pregnancies, which do not necessarily involve IVF procedures, fall off the statistical map. Of course some LGBTQ people do use IVF as part of surrogacy arrangements or for other reasons (e.g., lesbian reciprocal IVF), but the increased profits and contribution to clinic statistics stemming from LGBTQ clients is not significant enough to warrant a culture shift in the clinic. Fertility clinic culture is embedded in hegemonic heterosexuality, in the repair of damaged masculinities and femininities, and the bolstering of hyper-conventional gender norms because this is what draws the mainstay of their business. In the context of this culture and the investments of the fertility industry, what do LGBTQ people say they want?

Five Minutes with a Change Maker: What People Want

In March 2014, my colleagues and I published an article in the *Journal of Obstetrics and Gynecology Canada* (Ross et al., 2014) summarizing the recommendations the COF participants made in response to the last question they were asked: “If you could have five minutes with someone who could really make change in the AHR system, what would you want to say to them?” We suggest that one of the barriers to implementing these recommendations may be lack of education about LGBTQ health in medical school curriculum, resulting in physicians and other health care providers “lacking the basic information necessary to provide competent care to LGBTQ people” (p. 151). Interestingly, education is conceived as the *provision of information*, when in fact the most substantive recommendations from participants address quality of care and *quality of relations* between patients and providers. Some of these include:

- Consider the service user’s wishes and expertise in their own body in developing a plan of care.
- Provide care in a more personal, humanizing, or respectful manner.
- Actively involve the non-pregnant partner or co-parents in the process (i.e., recognize LGBTQ kinship structures).
- Service providers should be honest about what they do not know about LGBTQ people or family creation and ask questions respectfully, including asking direct, respectful questions to ascertain the relationships between all involved parties.

This emphasis on quality of relations, not-knowing and attentive listening is echoed in other research and substantiated by examples from the COF interviews. Harbin, Beagan, and Goldberg (2012), in an article about comfort and discomfort between LGBTQ people and medical practitioners, share this participant’s advice to medical practitioners:

> I wouldn’t say don’t even show your surprise but be honest about it and inquisitive… Be aware when you’re afraid of who you’re talking to, because that’s really I think what ignorance is about. It’s about being threatened by who you’re talking to or their experience. (p. 159)

This queer woman asks clinicians for honesty and inquisitiveness in the face of fear, even when it may mean the discomfort of experiencing discomfort. Other hints of what LGBTQ people want in their encounters with medical staff are audible in the words of COF participants. Rebecca describes her version of what good patient care should look like, and provides an example of an instance when she receives it:

> I guess I sort of thought I'd sit in a room, and someone would be like, "So, tell me your story."…My expectation was that I'd have an opportunity to be like, "Look, this is what *I* want."
>
> A month later or something I went to another doctor. She's a family doctor [who works in a fertility clinic] and I had a really different experience. At my first appointment, she's like, "So tell me why you're here." And that was great! …like they actually really said, "Why are you here? How can we help you? How should we work together?"

Nina, as we recall, articulates how she does not fit with what she perceives to be the clinic's assumptions about how a woman is supposed to feel about her body. She suggests that *all* clients could benefit from the removal of these assumptions and from an inquisitiveness and openness, in a sense, a stance of not-knowing, that would allow people to control their own narratives:

> That's what should happen for all clients: *you never know who you're dealing with and how they feel about their body.*

Stacey and Nina suggest that there is value in humility, that it is okay for practitioners to not know — to be ignorant, and to be inquisitive with good intent:

> Stacey: And also just, you know, having a bit of humility and deferential attitude. To not pretend that "We've had a lot of trans people in here before," you know, but to listen.
>
> Nina: Yeah, like if you're ignorant, just ask a question with good intention.
>
> Stacey: Yes, fine, be ignorant, that's okay.

People want inquisitiveness, ignorance, humility, a stance of not-knowing, space to self-define identities and kinship narratives, and listening from their practitioners.

Perhaps we can learn from a Levinas form of listening which, in Todd's analysis, is perhaps the "learning event par excellence" (2003, p. 131). The act of listening, when it does not adopt an attitude or a set of how-tos for practice, becomes an ethical response. Instead of seeking comprehension of the Other, it attends to the Other's alterity and allows for the possibility that one will be changed by the Other. Listening as receptivity and openness to the Other involves risk, uncertainty, and discomfort, potentially transforming the very grounds of one's self understanding (p. 132). As Todd puts it,

> Listening…as an approach to the Other that signifies "I can change," is a responsible mode of relationality in that it is a nonviolent and unpredictable response to alterity, even when my passivity results in my own discomfort. The one who listens risks nothing less than an alteration of self in responding to another's speech, and it is within this context of risk and alteration that listening is required for learning to take place (p. 136).

It is this quality of listening and of not-knowing that is required in encounters between LGBTQ people and fertility clinic staff. In practical terms this might manifest as an initial discovery session between new clients and a medical staff or intake person, involving open-ended questions and attentive listening with receptivity, curiosity, and openness. In such a session clients would be offered a space in which to disclose information about identities, practices, family configurations, and kinship relations as they chose. Instead of being squeezed to fit within a clinic structure and culture designed for somebody else, people would be given permission and space to define their own reproductive journeys, issues, and dilemmas. And in fact, such a process would be beneficial not only to LGBTQ AHR clients, but to *all* AHR clients, many of whom do not fit within the heteronormative and prescribed gender roles and kinship structures embedded in clinic practice.

The implementation of a session like this requires a significant shift in attitude and practice on the part of medical personnel. It means a shift from knowing to non-knowing, and the cultivation of an attitude of receptivity and openness in the face of the Other's alterity. How do those of us involved in social justice and/or diversity training in professional settings set about "teaching" medical experts, who are embedded in a multi-billion dollar industry and trained to believe in their own authoritative knowledge, to be humble, to adopt a stance of not-knowing, and to be open to and surprised by the encounter with the Other? Can "just like" narratives and recognition of sameness, or empathy, be useful in working toward LGBTQ intelligibility, or do they always work against it? What is required of us as educators to be effective in this work?

Pedagogical Questions

Contemplating these questions solely through the lens of institutional power, I am tempted to suggest that the stakes are too high, that the cultural, social, and financial investments of the fertility industry are such that the necessary shift in culture is too much to ask or expect. I recall Ahmed's observations about *solidity*, "about how what appears as mobile and changing *can hold its shape*," about the intransigence of institutions and the difficulty of social transformation (2012, p. 186). However, it is worthwhile to consider the complex tensions between institutional roles and personal relations.

In a discussion of teachers and the institutional settings in which they work, Todd suggests that although we are constricted by institutional rules and procedures, we always exceed our institutional roles through personal, inter-human interactions. Teachers, she argues, have an ethical responsibility that goes beyond their institutional roles and duties; responsibility is fundamentally a personal, practical matter (2003, p. 143) rooted in the relation to the Other. Conceiving of ethics as applied morality, as something that can be captured in codes of ethics or principles of conduct, masks the nature of responsibility that lies in the actual encounter with another person. While rules are necessary and often useful, they cannot ultimately exempt us from acting responsibly for the Other (p. 144). Todd offers examples, both micro and macro, of teachers refusing to follow rules or institutional regulations in order to accommodate a particular student's needs (pp. 142-43).

Similarly, I would argue, fertility clinic staff work within institutional systems, rules, and regulations, but also exceed them. The response of clinic staff to the semen regulations I described in chapter 4, involving recommendations to clients of ways to circumvent the regulations, are perhaps a good example of an ethical response superseding a rule-based one. Possibilities for change, then, lie in recognizing the "purely human and interpersonal dimension in which our responsibility is communicated" (Todd, 2003, p. 144). LGBTQ clients at fertility clinics want, more than anything, to be treated humanely in their interactions with clinic staff.

Social justice education, and I include institutional "diversity" training in this category, often hinges on the assumption that "corrective information, critical analysis, and empathic experience" (Taylor, 2009, p. 221) with or about a marginalized group will bring about change. Taylor (2009) cites the move in anti-bias education to accompany information about the Other, with "critical analysis of dominant culture's role in making the lives of others miserable" (p. 223) or what is often referred to as critically informed empathy. Pedagogical strategies might include

> exposing students to positive representations of marginalized groups, providing access to the voices of silenced populations, facilitating role-playing experiences that let students of dominant culture simulate marginalized people's oppressive experiences, and providing students with corrective information about the oppressive experiences of the members of such groups (p. 223).

Todd (2003) is particularly concerned with this kind of social justice education, asking two fundamental questions:

> First, are we (as researchers, teachers, and readers) enacting violences upon others as we engage their stories and narratives or self-identification, despite our best intentions? That is, in seeking to learn *about* them, can we be negligent of

> learning *from* them? And, second, if so, how might we attend to the Other and preserve alterity as a nonviolent alternative while working toward the aim of social justice? (p. 3)?

She argues that acknowledging the unknowable Other is the basis of a more ethical relation to the “many differences that are effected through power and social location” (p. 3). In other words, preserving the alterity of the Other is key to social justice. While I agree with Todd that, ultimately, ethical practice requires a turn from empathy to recognizing alterity, I raise questions about the role of empathy, both in clinical and pedagogical settings, in creating forms of affective connection which might allow or encourage openness and receptivity to alterity.

Interrogating Sameness

Ellen Lewin, in an early ethnography of lesbian motherhood, found that the lesbian mothers she interviewed “emphasized the centrality of their identities as mothers, representing motherhood as overwhelming or overshadowing other aspects of identity, including being a lesbian” (1995, p. 110). In other words, an identity as “mother” or “parent” often supersedes other identities, setting up a separation or divide between those who are parents and those who are not. Similarly, clients at a fertility clinic, regardless of sexual orientation, gender identity or family configuration, share a desire to become parents. In interactions with clinic staff, this shared desire or “sameness” with other fertility clinic clients can be a source of connection, comfort and reassurance. Sameness, in moments, has a place.

However, Lewin also articulates important concerns about the focus on sameness, arguing that lesbian mothers, in their identification with other mothers, may be seeking a form of legitimacy as “women,” a legitimacy formerly denied them *as lesbians*. This potentially sets up a new form of reproductive stratification in which lesbians can inhabit the category of “mother,” leaving non-mothers, particularly lesbian non-mothers, as still “not quite women” (p. 115).

Lewin's arguments point out, once again, the limits of a focus on sameness. While empathy and sameness have a place and can provide a useful starting point for connection, they must, ultimately be joined by an understanding of and openness to alterity. And perhaps the same is true in pedagogical settings. By way of example I refer to a presentation I offered recently to AHR service providers at the Canadian Fertility and Andrology Society (CFAS) annual conference.

In 2013 I delivered a plenary talk at the CFAS conference entitled "Exploring Models of Care: LGBTQ People and Fertility Clinics." The presentation opened with photos of a pregnant me, my newborn child, and the (many) people who were present as she entered the world, followed by an image of her birth registration form which at the time could list only one of her moms —her other mother was absent from the form. I offered a history of LGBTQ parenting in Canada, beginning with stories of lesbians and gay men losing their children in custody cases in the 1970s and '80s, provided information about definitions, language, and terminology and presented data from the COF study about LGBTQ people and AHR services. I concluded with another photo of my family, as well as my daughter's corrected birth registration which included the names of both her moms, the result of a 2007 Charter of Rights and Freedoms challenge that changed Ontario birth registration procedures.

Following this presentation I asked people to fill out a questionnaire. When asked what they learned from the presentation, three things stood out: the emotional impact of hearing about the recent history of LGBTQ people losing their children in custody cases; interest in legal developments, including birth registration developments; and lack of familiarity with or knowledge about *heterosexism*, a term and concept new to many, in contrast to *homophobia*, which was familiar to most people.

Many of those in attendance were parents, and most parents can relate both to the desire to have children and to the tragedy of losing them. On reflection, I wonder: did an empathic connection to me, as a fellow parent, and to larger LGBTQ communities historically, encourage receptivity to what was unfamiliar and not known? While I understand Todd's view that empathy cannot be "called for" because it arises in spontaneous, unpredictable, and surprising ways, in the above example, the fact that people experienced a connection based on something they know — parenthood, perhaps left them more willing and able to explore the impact of heterosexism on the lives of LGBTQ people —something they do not, and cannot, know. The recognition of sameness, *learning about* the Other, can create a connection that opens the door to recognition of alterity and to *learning from*. *Knowing* something of the Other can provide a doorway to *not knowing*.

Teaching Not-Knowing

I have spent the past 20 years educating within LGBTQ communities and conducting training sessions, lectures and presentations in a huge range of professional and academic settings. I have worked with students of midwifery, nursing, medicine, social work, criminology, education, gender/women's students/sexual diversity, and have conducted workshops in hospitals, legal settings, educational institutions, board rooms and fertility clinics. My goal in all this work is to create an environment in which people feel comfortable to ask difficult or uninformed questions about sexuality, gender and LGBTQ identities, and in which people can begin to unpack and critically explore ideas and beliefs they may not even be conscious that they hold. I pride myself on being an empathic, humorous, open, approachable, knowledgeable, and effective trainer.

Early in most training sessions I raise questions of *comfort* and *discomfort*. I ask people to reflect on the earliest things they recall learning about lesbian and gay people, which typically are mostly negative, sometimes extremely so. We talk about the often-unconscious impact of these beliefs or, in many cases, silences, and the need, in a move to become a “queer-positive” professional, to reflect on, talk back to, and, in some cases, unlearn them — the goal being to increase one’s comfort level in working with LGBTQ people. (I am referring here to educational settings in which most of those present are cisgender and straight — different strategies are called for when service providers are queer themselves). I often begin this discussion by sharing the following quote from a lesbian participant in a research study on the perinatal experiences of queer women:

> Every time I’m in a health situation, they’ll always ask, would you like your husband to come in, and I’ll just say no, my “friend” is here… I think it’s because I’m hesitant to create a situation where I think there’s going to be discomfort because it makes me uncomfortable when they get uncomfortable and I don’t want that. (Mothering on the Margins (MOMS) participant, 2004 as cited in Ross, Steele, & Epstein, 2005)

As I understand her, this woman is suggesting that central to the practice of professional queer-positivity is a basic “comfort” with Otherness. A provider can say the right words and ask the right questions, but if they are projecting a vibe of discomfort and unease, this can speak louder than anything else. Lucy, from the COF project, describes a couple of instances where she encounters this discomfort in practitioners:

> …that awkward conversation where I say something and …just like their face goes, kind of like that blank look. “Oh my god, this makes me really uncomfortable” and I have to think of some light-hearted joke to make…
>
> They were like, “Okay, mother, father.” And I was like “No, he has two mothers.” The nurse was like…frozen for a really long time. I was like, “Oh no, someone unfreeze her…she doesn’t know what to do.”

In these situations clients sense the discomfort in their service providers which can lead to a lack of disclosure and a sort of role reversal, where the client begins to take care of the person who is supposed to be taking care of them. A service provider or practitioner seeking to become more comfortable seems like a worthwhile goal.

However, in an effort to seek comfort, people sometimes move instinctively to a search for what is familiar in the Other. Seeking the known and the familiar is easier than remaining in the place of discomfort or disorientation brought on by an encounter with the Other who is always unsettling, and therefore discomfiting, to the Self. The pedagogical question becomes *how do we, as educators, encourage conditions that will contribute to practitioners' comfort with not knowing and with the disorientation that comes from encounters with the unfamiliar?* If, as diversity educators, our aim is to shift the quality of relations in professional settings, what can we do pedagogically to encourage receptivity to Otherness and alterity?

When we enter pedagogical spaces, our students or participants become the Other to whom we are responsible. We do not know their personal histories, their feelings about the work they do, or the meanings they bring to it. If we take responsibility to listen to them, not from a position of knowing, but from one of ignorance, we *model* the relations we seek, that is, a stance of openness, receptivity, and not knowing. My experience in pedagogical settings tells me that *something* happens prior to receptivity to the Other, and that this is related to the stance of the educator. How do we establish a learning environment in which teachers and students, presenters and audience members, facilitators and participants can engage in a mutual process of not knowing in a non-judgmental pedagogical space where it is *okay* to not know, to be vulnerable, to ask questions, and to engage in dialogue.

Assuming that training for professionals consists of a set of Power Point slides that anyone can present negates the impact of the relations and personal interactions that take place in this setting. Pre-fixed ideas about knowledge transfer and pedagogical outcomes stand in the way of the learning that can come from openness and a receptivity to difference and to what can be learned from the people in the room. As Todd puts it, "intentionality reduces the risks so necessary for learning and ethical interaction and becomes a form of defense against the unpredictable challenges of the Other" (2003, p. 145). In our role as educators we need to pay attention to the nature and the quality of the relations and interactions that we practice as we teach. And when the students are professionals who will take what they learn back into their own practice, modelling the stance one hopes to encourage can be a powerful pedagogical tool.

Of course, this is easier said than done and, as all educators know, students will say and do things we don't like. We are confronted with students whose values clash with our own, and who, in one form or another, resist engagement. If, in these moments of discomfort, we can retain connection, remain open to learning and to an awareness of our own affective responses and our own ignorance, without knowing where things are going and without drawing on pre-packaged responses, something surprising can happen. If we engage, not as experts, but in a mutual exploration of the subject at hand, offering our knowledge and perspective where it fits but remaining open to new perspectives and to the knowledge and experience of those in the room, we can begin to shift institutional habits rooted in "knowing about" the Other.

The COF study provides a rich and vivid picture of LGBTQ people's interactions with AHR services in Ontario and makes recommendations for change on many levels. The study offers practical suggestions such as the recommendations to:

- Use inclusive language (that does not presume heterosexuality, cisgender identities, or particular family configurations).
- Revise forms and documentation to reflect the diversity of sexual orientations, gender identities, and family structures of individuals accessing fertility clinics.
- Increase LGBTQ visibility on websites and images in the clinic, and in provided porn.
- Create gender-neutral washrooms near ultrasound rooms and andrology labs.

And, on another level, the study makes recommendations that echo the issues I raise in this dissertation — a dismantling of the heterosexual matrix's assumptions; recognition of the diversity of LGBTQ kinship relations; a stance of not-knowing, receptivity, and openness; and recognition that LGBTQ (and all) fertility clinic clients are the experts on their own bodies and reproductive desires. (For the specific recommendations, see page 168 of this dissertation.) The COF participants stated clearly that most important to them is the quality of their interactions with fertility clinic staff.

My experience has been, however, that service providers, when they begin to pay attention to LGBTQ inclusivity, tend to focus on the practical and pragmatic recommendations at the expense of the more complex, interpersonal and interactional ones. In particular, people focus on intake forms, perhaps viewing this as a simple and straightforward step toward improving LGBTQ accessibility. Implementing these more practical recommendations does, of course, contribute significantly to improving the quality of LGBTQ experience with AHR services, and their absence results in violations. However, paying attention to practical matters without incorporating a deeper understanding of the social relationships, sexual and gender identities, and family configurations involved, and without attending to issues of recognition and alterity, can result in things like “married, single, or gay” as check boxes on an intake form, or a separate form for “same-sex couples” which does not ask about a male partner. I have yet to see a revised form that truly creates space for the spectrum of LGBTQ identities, bodies, and kinship configurations, though such forms do exist.[2]

I am not suggesting that we stop encouraging clinics to change their intake and procedure forms, to establish gender-neutral washrooms, to expand their porn collections, to improve their websites and to be transparent about their fee structures. Nor should we discontinue lobbying for provincial health coverage for AHR services, or for family law that adequately recognizes and protects queer and trans families of all configurations. However, the COF participants were most

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[2] See, for example, the intake forms of the Sherbourne Health Centre or Hassle Free Clinic, in Toronto

concerned about the *quality* of the personal, inter-human interactions that are at the core of their experiences in fertility clinics where their bodies and identities are frequently misrecognized and unintelligible. Unless we pay equal or more attention to these relations, and to the pedagogical questions that they raise in relation to “diversity” training, we will never achieve the kind of substantive and systemic change the COF participants are calling for.

Appendix A: Lesbian and Bisexual Women's Recommendations for Improving the Provision of AHR Services

Lori E. Ross, PhD, Social Equity and Health Research Section, Centre for Addiction and Mental Health, Toronto, ON

Leah S. Steele, MD, PhD, Department of Family and Community Medicine, St. Michael's Hospital, University of Toronto, Toronto, ON

Rachel Epstein, MA, Coordinator, LGBTQ Parenting Network, Sherbourne Health Centre, Toronto, ON

Recommendations

- Staff should be trained to be culturally competent in relation to LGBT communities — to be aware of and sensitive to the needs, concerns, and sensibilities of LGBT clients, including the specific needs of transidentified clients.
- Intake and procedure forms should explicitly make room for family configurations that do not assume male/female relationships, or a two-parent model — i.e., that recognize the sometimes complex family configurations that LGBT people, and others, are forming.
- Welcome the involvement of all parties desired by patients, including partners, known sperm donors, and co-parents.
- Provide accessible fertility services for known sperm donors, including gay men.
- Minimize costs for services and communicate a consistent fee structure.
- Ensure that language and treatment recognizes that LGBT people are often accessing fertility clinics and sperm banks as part of routine family planning and not as infertility clients.
- Provide opportunities for women to make informed choices about interventions that are consistent with their known or presumed fertility.

- Offer infertility support that is specific to lesbian and bisexual women (e.g., specialized groups) or is provided by individuals who are knowledgeable about issues relevant to lesbian and bisexual women.
- Provide cues that services are LGBT positive. These might include positive space imagery or posters and brochures depicting LGBT families. Individual service providers can provide cues that they are open to LGBT families through choice of gender-neutral language, and attention to how questions are posed.
- Ensure that information is available about local LGBT services, supports, and resources. Where feasible, offer LGBT-specific services or services in partnership with LGBT communities and/or service providers.
- Expand the selection of donor semen, particularly with respect to donors of diverse ethno-cultural origins and identity release donors.
- Strive for a unified standard of care across geographic regions, and facilitate access for people living outside of major urban centres.

Appendix B: Advisory Committee Members

Research Team

Lori Ross

Rachel Epstein

Leah Steele

Stu Marvel

datejie green

Scott Anderson

Lesley Tarasoff

Advisory Committee Members

COMMUNITY

Nicole Nussbaum — Community member

Mark Knauf-Nakamura —Community member

Robin Fern — Community member

Omo Akintan — Community member

Chris Veldhoven — Queer Parenting Programs, 519 Community Centre

SERVICE PROVIDERS

Dr. Norman Barwin, Ottawa

Dr. Anthony Auyeung, Toronto

Dr. Clifford Librach — CReATe Fertility Centre

Dr. Sergey Moskovtsev —CReATe Fertility Centre

Debbie Davies, RN — CReATe Fertility Centre

Dr. Marjorie Dixon — First Steps Fertility

Dr. Alfonso Del Valle — ReproMed

Dr. Tamer Said— ReproMed

Jan Silverman — Fertility counsellor, Women's College Hospital

Dara Roth Edney — Fertility counsellor

Appendix C: Selected Demographic Characteristics of Participants

Gender Identification	**Number of People (Percentage)**	
Female (cisgender)	48 (72.7)	
Male (cisgender)	9 (13.6)	
Trans man/FTM spectrum	7 (10.6)	
Trans woman/MTF spectrum	2 (3.0)	
Sexual Orientation		
Lesbian	21 (31.8)	- 1 also identified as queer
Queer	18 (27.3)	
Gay	11 (16.7)	- 2 also identified as queer
Bisexual	11 (16.7)	- 1 also identified as queer/pansexual
Two-Spirit	1 (1.5)	- also identified as bisexual
Straight	2 (3.0)	- both identified as trans
Other	2 (3.0)	- included: homoandrophilic, fluid/no label
Cultural/Racial Background		1 missing. Participants could select more than one so frequencies do not total 100%
White	48 (72.7)	
Mixed	8 (12.1)	
Black/African/Caribbean	6 (9.1)	
Aboriginal	3 (4.5)	
South Asian	2 (3.0)	
Other	3 (4.5)	
Relationship Status		2 missing
Legally married	37 (56.1)	
Common-law	20 (30.3)	
Partnered	2 (3.0)	
Multiple partners	1 (1.5)	
Single	6 (9.1)	
Divorced	1 (1.5)	

Region in Ontario		
Toronto	34 (51.5)	
Southwest	10 (15.1)	
Eastern	9 (13.6)	
North Eastern	4 (6.1)	
Hamilton/Niagara	3 (4.5)	
Central East	2 (3.0)	
Central West	2 (3.0)	
Northwest	2 (3.0)	
Highest Level of Education		3 missing
High school	1 (1.5)	
College	7 (10.6)	
University	24 (36.4)	
Postgraduate	31 (47.0)	
Household Income (CAD)		3 missing
Under $20,000	1 (1.5)	
$21,000-$35,000	2 (3.0)	
$36,000-$50,000	4 (6.1)	
$51,000-$65,000	6 (9.1)	
$66,000-$80,000	15 (22.7)	
$81,000-$100,000	8 (12.1)	
Over $100,000	27 (20.9)	
Age		
Mean (range)		
26-30	7 (10.6)	
31-35	22 (33.3)	
36-40	21 (31.8)	
41-45	15 (22.7)	
45-50	1 (1.5)	

Appendix D: Interview Guide

Creating Our Families (COF): A Pilot Study of the Experiences of Lesbian, Gay, Bisexual, and Trans People Accessing Assisted Human Reproduction Services in Ontario

1. Tell me about how you (you and your partner, your co-parent) came to the decision to have kids.

   In this study, we're interested in hearing about peoples' experiences with assisted human reproduction, or AHR, services. AHR services include things like donor insemination, *in vitro* fertilization, egg donation, and other services that are typically offered through fertility clinics, doctor's offices, and sperm banks.
2. How did you come to consider AHR services as a possibility in building your family?
   1. Did you consider or try any other options for having children?
   2. When you were making your decision to use AHR services, where did you go for information about AHR? (How did you find out where to go for information? Was there any particular information you couldn't find or had difficulty finding? Did you come across any specific information for LGBT people about AHR?)
   3. (*If used services*) What services, processes, or programs did you make use of? (Who used them? You, your partner, your co-parent, a donor, a surrogate, someone else?)
3. What did you imagine [the service] would be like?
   1. Were you looking forward to your first visit? Feeling apprehensive? Did you have any specific worries or concerns?
4. (*If they accessed any services, otherwise skip to question 10*) Tell me about the first steps you took when you decided to access AHR services.
   1. How did you get a referral?
   2. How did you decide which AHR clinic to work with? (Did you have a choice?)

5. Tell me about your first interactions with [the service].
    a. Did you feel welcomed, uncomfortable, etc.?
    b. Did they have any LGBT-specific resources?
6. Tell us about the process after that.
    a. What providers were involved in your care?
    b. Who went with you to your appointments?
    c. Can you remember a particularly good or bad experience with your provider or clinic that you would like to share with us?
    d. Thinking back on your experiences, would you say you faced any particular challenges or difficulties in accessing AHR services? (Were these barriers related to your sexual orientation or gender identity? How?)
    e. Was there anything that happened during the process that was really helpful to you?
    f. (*If applicable—FERTILITY INTERVENTIONS*) Was it ever recommended that you take fertility drugs, or have any other interventions related to your fertility? How did you feel about that? (Did you feel like you were given a choice whether or not to have these interventions? Did you have all of the information you needed to make a decision? Did you feel like you were in control of your care?

    g. (*If applicable—COMING OUT*) How did you decide whether or not to out yourself to your AHR service providers? (At what stage did you decide to come out? Did you come out to everyone or only to some providers? What kind of reactions did you get when you came out? Did you ever feel you had to conceal your sexual orientation, gender identity, or family configuration? Why did you feel that way? What was that like for you?)
    h. (*If applicable—LEGAL ISSUES*) Were there any legal issues that arose?

9. Were you offered or required to have a counselling visit prior to receiving AHR services? (If yes, did you have one?)
    a. What was your experience with the counselling process?
    b. What did you talk about?
    c. Was there anything about the counselling session that was particularly helpful?
    d. Anything that seemed unhelpful or inappropriate to you?
    e. (*If applicable*) Was there any concern expressed about having different-sex role models for your children?
10. (*For those who did not use services, otherwise skip to question 12*) So I understand from the information you gave us over the phone that you ultimately did not use AHR services. Can you talk about the factors that led to that?
    a. Did you choose not to use services, or was that decision made for you by someone else? (Who? Why?)
    b. Were there any issues specifically related to your sexual orientation or gender identity?
    c. Were there any issues related to cost of services? Other practical issues?
11. Did you continue to try to build a family after AHR services were no longer a possibility for you?
    a. (If yes) How did you go about doing that?
    b. (If no) Why did you decide to stop?
12. Thinking back on your experience, do you feel that you had any unique experiences or needs related to your identity as a *insert relevant identity/ identities* (lesbian, gay man, bisexual person, and/or trans person)?
    a. What about other identities that are important to you? (probe: age, race/ethnicity, social class, disability)
    b. (*If participant lives outside of the GTA/Ottawa*) Do you think there is anything unique about your experiences with AHR services because you

live here? (Did you have to travel to access services? How far? What was that like for you?)

13. Based on your experiences, if you had five minutes with someone who could really make change in the AHR system, what would you recommend to them?
14. Is there anything we haven't covered that you feel is important for us to know about?

Appendix E: Consent to Participate in a Research Study

Study Title. Creating Our Families: A Pilot Study of the Experiences of Lesbian, Gay, Bisexual, and Trans People Accessing Assisted Human Reproduction Services in Ontario

INVESTIGATORS

Lori Ross, PhD, Centre for Addiction and Mental Health

Leah Steele, MD, PhD, Centre for Addiction and Mental Health

Rachel Epstein, MA, LGBTQ Parenting Network, Sherbourne Health Centre

Stewart Marvel, MA, LLM, Osgoode Hall Law School, York University

Study Sponsor: Canadian Institutes for Health Research

Introduction

You are being invited to participate in a research project. This consent form provides all of the information about this research project in order to assist you in deciding whether or not you wish to participate.

Before agreeing to participate in this research study, it is very important that you read and understand all of the information on this form. If you have any questions after you have read the form, you will be given as much time as you like to discuss them with the study investigator. You should not sign this form until you are sure that you understand and agree to all of the information about the research it provides.

Purpose of this Research

- Research on families formed through Assisted Human Reproduction (AHR) services (e.g., cycle monitoring, donor insemination, egg retrieval, sperm collection, in vitro fertilization, surrogacy) has focused on heterosexual relationships. However, there has been little research on the experiences of lesbian, gay, bisexual, and trans (LGBT, please see Glossary at the end of this form) people who use AHR services, or who have considered using these services, but have decided not to. The few available data suggest that LGBT people may face significant barriers to AHR services.

- The goal of this research is to understand the experiences of LGBT people who access, attempt to access, or have considered accessing AHR services in Ontario since January 1st, 2007.
- Part of this goal will be to explore the impact of the Assisted Human Reproduction Act (AHRA) on LGBT people in Ontario.

Description of the Research

Who will be participating in this study?

People who identify as LGBT and have used, considered using, or tried to use AHR services in Ontario since January 1, 2007.

If I choose to participate, what will I be asked to do?

1. Carefully read, consider, and sign this consent form. Once you have read and signed the consent form, you can return it to the interviewer. You will be given a copy to keep.
2. Take part in a one hour interview in which you will be asked to tell your story of using or attempting to use AHR services, or of considering but choosing not to use these services.
    - We will make an audio recording of the interview. However, if you do not wish to be audio recorded, please let the interviewer know and he/she will take written notes of the interview.
    - During the interview you will be asked to provide details about your decision to use or not to use AHR services, and your related and/or resulting experiences.
    - The total interview will not take more than 1 hour. You can take a break from the interview any time you like, and if you are unable to finish the interview at the scheduled time, your interviewer will offer to schedule another time to finish the interview with you.
3. Fill out a short, demographic questionnaire.

Potential Harms (Injury, Discomforts or Inconvenience)

- There are no known harms associated with participation in this study.

- It is possible that some of the questions you are asked may cause you to feel upset. If you feel upset, the interviewer can provide you with contact information for community support and/or mental health agencies that may be able to help you. You will also be encouraged to discuss any concerns you have with your family doctor. If you are uncomfortable with any of the questions or want to stop at any time during the interview, let the interviewer know.

Potential Benefits

You will not directly benefit from participating in this research study.

Confidentiality and Privacy

Your participation in this research is confidential (see glossary in Appendix H). Your responses to the questions in the interview will be available only to the study investigators listed at the top of this consent form, and specific trained research staff who are bound to our research protocol and confidentiality agreement.

- Study investigators are required to report to the authorities if it is clear that you or someone else is at risk of immediate danger, or if they have any reasonable suspicions of neglect and/or physical or sexual abuse of a person less than 18 years of age. Other than these legal exceptions, your responses to the interview will not be available to any individuals or organizations outside of the research team.
- No information that reveals your identity will be released or published without your consent. Your responses and information will be held in strict confidentiality, and will be protected to the limits of the law.
- All data will be safely stored in a locked facility and only research staff will have access to this information.
- If you wish to participate in this study, but require anonymity of your records, you may select the option for anonymity on the signature page of this document (page 6). If you select this option, we will ensure the following:
    - Once the interview is completed, we will remove from all transcripts and notes any information that may identify you and your family.

    - We will remove and/or delete all reference to your participation in this project so that none of your identifying data remain on record with us.

Compensation

You will be compensated $25.00 for your participation. Even if you choose to withdraw from the study before the end of the interview, you will still be compensated.

Participation and Withdrawal

- You can choose not to participate in any part of this research study, and you can choose not to answer any questions you are asked as part of the interview.
- If you choose to participate in this study, you can stop your participation (i.e., withdraw from the study) at any time without any effect on the care you receive. In addition, you do not lose any of your legal rights by signing this consent form. Your decision not participate, or to withdraw your participation, will not influence the nature of your relationship with the researchers, Sherbourne Health Centre, CAMH, York University or any other group associated with this project, either now, or in the future.
- If you decide to withdraw from the study before the end, the investigators will ask you if they can still use the data you have provided to them to whatever extent possible. Should you say no, we will destroy your data.

Contact Information

- If you have any questions about your rights as a research participant in this study, you may contact Dr. Padraig Darby, Chair, Research Ethics Board, Centre for Addiction and Mental Health, at 416-535-8501 ext. 6876, or Ms. Alison Collins-Mrakas, Senior Manager and Policy Advisor, Office of Research Ethics, York Research Tower, York University at 416-736-5914.
- If you have any questions about this research or your participation in this study, please contact the Principal Investigator, Dr. Lori Ross, at (416) 535-8501 ext. 7383, or Secondary Investigator, Stewart Marvel, at (647) 669-4144.

Appendix F: Demographic Questionnaire

Creating Our Families (COF): A Pilot Study of the Experiences of Lesbian, Gay, Bisexual, and Trans People Accessing Assisted Human Reproduction Services in Ontario

The following questions will ask you about your age, education, employment, relationship status, etc. This information will be used to get a big-picture idea of the people who participated in this study. All information provided by you will remain confidential.

1. How old are you?

☐ 16 – 25
☐ 26 – 30
☐ 31 – 35
☐ 36 – 40
☐ 41 – 45
☐ 45 – 50
☐ 50 – 60
☐ Over 60

2. What is your current relationship status? Please select all that apply.

☐ Legally married
☐ Common law/living with a partner
☐ Partnered / not living together
☐ Multiple partners
☐ Single
☐ Separated
☐ Divorced
☐ Widowed
☐ You don’t have an option that applies to me
Alternative:

3. How do you describe your sexual orientation?

4. How do you describe your gender identity?

5. Do you identify as a person living with
a) a disability
- ☐ Yes
- ☐ No

and/or b) a chronic illness?
- ☐ Yes
- ☐ No

IF Yes a) What is the nature of your disability? ____________________________

b) What is the nature of your health condition? ______________________

6. Have you tested positive for HIV?
IF Yes Did you learn of your status before or after considering AHR?

7. Do you currently have children?
- ☐ Yes
- ☐ No

IF Yes a) How many in total?

b) How many are living with you?

c) How old are they?

8. Where were you born?
- ☐ Canada
- ☐ Outside Canada

9. If you were born in Canada, please skip to question 11.
If you were born outside Canada, in which country were you born?

10. How many years have you lived in Canada?

11. How do you define your cultural and/or racial background?

12. What is your current employment status?
- ☐ Full-time employed
- ☐ Part-time employed
- ☐ Student
- ☐ Not employed
- ☐ Retired
- ☐ On disability
- ☐ On maternity/parental leave

☐ You don’t have an option that applies to me
____

13. How would you describe your highest level of education?
☐ Less than high school
☐ High school some or completed
☐ College some or completed
☐ University (e.g. BA, BSc) some or completed
☐ Post Graduation (e.g. MA, MSc) some or completed

14. What is your approximate household income?
☐ under $20,000
☐ $21,000–$35,000
☐ $36,000–$50,000
☐ $51,000–$65,000
☐ $66,000–$80,000
☐ $81,000–$100,000
☐ over $100,000

Thank you for your participation

Appendix G: Ethics Approval — CAMH Research Ethics Board

PROTOCOL REFERENCE #048/2010

June 2, 2010

Dr. Lori E. Ross, PhD
Research Scientist
Social Equity & Health Research Section
Centre for Addiction and Mental Health
455 Spadina Avenue, Suite 300
TORONTO ON M5S 2G8

Dear Dr. Ross:

Re: Research protocol #048/2010 entitled "Creating our families: A pilot study of the experiences of lesbian, gay, bisexual, and trans people accessing Assisted Human Reproduction services in Ontario" by Ross L., Steele L., Epstein, R.

We are writing to advise you that the Centre for Addiction and Mental Health Research Ethics Board (CAMH REB) has granted approval to the above-named research study **for a period of one year from the date of this letter**1. IF THE STUDY IS EXPECTED TO CONTINUE BEYOND THE EXPIRY DATE, YOU ARE RESPONSIBLE FOR ENSURING THE STUDY RECEIVES RE-APPROVAL BY SUBMITTING THE CAMH REB "ANNUAL RENEWAL OF ETHICS APPROVAL" FORM ON OR BEFORE **May 1, 2011**. Should the study be completed prior to the annual renewal date, please submit a final report. **The level of continuing review for this study is Level 2**.2

The revised "Consent to Participate in a Research Study" and advertisement received May 18, 2010 have been approved and are attached. **Subjects should receive a copy of their consent form.**

Please contact Polly Thompson, Manager, CAMH Research Communications, ext. 4932 prior to using any advertisement.

During the course of the research, any significant deviations from the approved protocol (**that is, any deviation which would lead to an increase in risk or a decrease in benefit to human subjects**) and/or any unanticipated developments within the research should be brought to the attention of the Research Ethics Office. Best wishes for the successful completion of your project.

Yours sincerely,

Susan Pilon, MHSc
Manager, Research Ethics Office, CAMH

Appendix H: Glossary of LGBTQ Terms

Term[1]	**Definition**
Sexual Orientation	A person’s sexual orientation is defined by the gender(s) to which he or she is sexually attracted. Examples: gay, straight, bisexual, lesbian.
Gay	A male whose primarily sexual orientation is to other men. This term is sometimes used by lesbians (i.e., gay woman).
Lesbian	A female whose primary sexual orientation is to other women.
Bisexual	A person whose sexual orientation is directed towards individuals of more than one sex or gender, though not necessarily at the same time.
Queer	A term that has traditionally been used as a derogatory and offensive word for LGBTQ people. Many have reclaimed this word and use it proudly to describe their identity and/or as an umbrella term for LGBTQ people or communities.
Heteronormativity	The assumption, in individuals or in institutions, that everyone is heterosexual, and that heterosexuality is superior to homosexuality and bisexuality.
Gender Identity	A person’s own identification of being masculine, feminine, male, female, or trans. Gender identity is unrelated to sexual

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[1] This glossary of terms was compiled by L.A. Tarasoff in May 2012 and was included as part of the consent form given to participants in the COF project. This is not meant to be a standardized list of definitions. Because ideas and attitudes are constantly changing within LGBTQ communities and among society at large, these definitions may be used differently by different people and in different regions. Many of these terms have been adapted from the following sources: Barbara A. M., Doctor, F., & Chaim, G. Glossary. In *Asking the right questions 2: Talking about sexual orientation and gender identity in mental health, counselling and addiction settings*. rev. ed. (Toronto, ON: Centre for Addiction & Mental Health, 2007: 55-60); Bauer et al., 2009; Green E., & Peterson E. N, LGBTQI Terminology. Available at: http://www.lgbt.ucla.edu/documents/LGBTTerminology.pdf Accessed January 8, 2012.

	orientation; not all trans people identify as lesbian, gay, bisexual, or queer.
Gender Expression	The public expression of gender identity; actions, dress, hairstyles, etc., performed to demonstrate one's gender identity.
Cisgender	A person whose gender identity matches the gender they were assigned at birth; someone who is not trans.
Trans	An umbrella term referring to people who do not embrace traditional binary gender norms of masculine and feminine and/or whose gender identity or expression does not fit with the one they were assigned at birth; can refer to transgender, transitioned, and transsexual people, as well as some two-spirit people.
Transgender	An umbrella term describing anyone who falls outside of traditional gender categories or norms. Literally means "across gender," and conveys the idea of transcending the boundaries of the gender-binary system. Not necessarily a desire to be of the "opposite" sex.
Transsexual	Someone who feels their gender identity does not match the sex that they were assigned at birth. Many transsexual people choose to go through sex reassignment, including hormone treatment and surgeries, so that their sex and gender identity match.
Transition	The process of changing from the sex one was assigned at birth to one's self-perceived gender. May involve dressing in the manner of the self-perceived gender, changing one's name and identification, and undergoing hormone therapy and/or sex reassignment surgeries to change one's secondary sex characteristics to reflect the self-perceived gender.
FTM	Trans man; a female-to-male transsexual; someone who was assigned as female at birth and identifies as male.
MTF	Trans woman; a male-to-female transsexual; someone who was

	assigned as male at birth and identifies as female.
Two-Spirit	An English-language term used to reflect specific cultural words used by First Nations people who have both a masculine and a feminine spirit or to describe their sexual, gender, and/or spiritual identity.

References

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