

The (Bio)Medicalisation, Stratification and Racialisation of Reproduction through Matching in UK Egg Donation

Thesis

Presented for the degree of Doctor of Philosophy

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Declaration of Authorship

I Priya Davda hereby declare that this thesis and the work presented in it is entirely my own.

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Abstract

The stage of ‘matching’, commonly described as ‘donor selection’ or ‘donor allocation’, is an integral stage in the egg donation process and refers to the selection of a particular donor for a particular recipient for the purpose of reproduction. Despite the model of clinic-mediated matching being an ‘institutionalised practice’ in the UK much of the literature on egg donation has taken this stage for granted. This study set out to explore the organisation of matching in egg donation in two fertility clinics in South East England. Ethnographic fieldwork was conducted over two years and involved observations, in-depth interviews with clinicians and recipients and the collation of matching statistics. Theoretical frameworks of (bio)medicalisation, stratification and racialisation were utilised to understand the matching process, with a particular emphasis on their application in the UK regulated context of egg donation.

In this study ‘matching’ was taken to be a process rather than a single practice of selection, enabling insight into how different sets of aims, activities, decisions, trajectories, roles, tools, constraints, perceptions and interactions at different stages of the matching process combine to result in particular outcomes. Situated within the wider regulatory context of the UK and the immediate clinical contexts in which research took place this study showed how donor-recipient matching in egg donation simultaneously (bio)medicalised, stratified and racialised reproduction in novel and nuanced ways, particularly through practices of ‘racial matching’ and ‘transracial matching’. Concepts of ‘kinship risk’, ‘marked whiteness’ and ‘strategic rationalisation’ were employed to understand the perceptions and practices of clinicians and recipients in the matching process.

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Chapter 1: Introduction

1.1 Introduction

This study set out to explore the organisation of donor-recipient matching in egg donation in the UK. The stage of ‘matching’ (i.e. donor selection) is an integral stage in egg donation and refers to the pairing of a particular donor and a particular recipient for the purpose of reproduction. Despite the model of clinic-mediated matching being an ‘institutionalised practice’ in the UK (Haimes, 1992) much of the literature on egg donation has until recently paid little attention to this process. As such, researchers have only alluded to matching as part of wider studies on gamete donation, in contexts of donor selection by recipients themselves or in neo-liberal contexts with little regulation and a relatively high supply of donors, or have explored recipients’ selection of donors outside of the clinical context.

Researchers who have explored matching in any-depth have predominantly focused on the construction of resemblance between recipients and donors and on recipients’ preference for desirable differences. These researchers have theorised matching as a kinship practice, a consumer practice and, relatedly, as a ‘biomedicalized’ practice. Studies that have given the topic of matching some primacy, have predominantly taken place in international and transnational contexts of egg donation. These contexts were often associated with having low regulation, a highly commercialised environment and a high supply of donors. For example, egg donation agencies, which exist specifically to recruit donors, are commonplace in neo-liberal contexts of egg donation, such as the USA. Indeed, studies on transnational contexts of reproduction have reported that individuals travelled abroad to escape the regulatory context of their home countries, and its implications, such as long waiting lists for egg donors (Bergmann, 2011; Culley et al., 2011; Hudson et al., 2016).

This has significant implications for the study of matching in the UK context, which is characterised by a high level of state regulation, a relative shortage of donors and long recipient waiting lists for egg donors. Whilst UK policy on matching in gamete donation has changed over time, there has nonetheless remained an inherent assumption in policy that it is clinicians, not recipients, who will select donors. It is important, therefore, to account for the constraints of the UK context, in particular the regulatory framework, a shortage of egg donors, and the particular roles, experiences and negotiations of clinicians and recipients, in understanding how matching is organised and undertaken in the UK context of egg donation. The current research explores these facets

1.2 Background to the ‘Research Problem’

1.2.1 Egg Donation and Matching

Egg donation is a type of fertility treatment that comes under the umbrella Assisted Reproductive Technologies (ARTs). Egg donation refers to the process by which one group of women, egg donors, donate their reproductive gametes to enable another group of women, recipients, to conceive and raise a child. More recently, recipients of donor eggs have included single and gay men. Typically, a donor’s eggs are fertilised by the partner of a recipient, with the intention that the recipient becomes pregnant from the transfer of embryo(s) created using the donor eggs and becomes the mother of any child conceived. Unlike sperm donation, egg donation is predicated upon the clinical context and requires high, rather than low, technological intervention. Egg donation can be undertaken using a ‘known donor’, where a recipient recruits their own donor, or, more typically, using an ‘anonymous donor’. The use of an anonymous egg donor, which is the focus of this study, necessitates the need for a

recipient to be paired with a donor. Donor-recipient matching refers to this pairing of a particular egg donor with a particular recipient.

Matching is significant for several reasons. Firstly, matching determines the types of families that are reproduced through egg donation, not merely the types of children and parents that are reproduced (Thompson, 2005). Secondly, matching determines recipients' access to treatment and reproduction even after they have gained access to the clinic, i.e. by virtue of their access to donors (a necessary precondition of treatment). Finally, matching is significant because it is implicated with the daily reinforcement and reproduction of 'race', inequalities and medical power.

1.2.2 Overview of the Matching literature

Matching has often been looked at peripherally in studies on gamete donation, which have often focused on other aspects of the egg donation process. Existing literature has predominantly focused on areas such as recipients willingness to disclose to their child (Readings et al., 2011; Murray and Golombok, 2003; Greenfeld and Klock, 2004; MacDougall et al., 2007), the experiences and socio-psychological functioning of donor-conceived parents and children (Brewaeys et al., 1997; Golombok et al., 1999; Murray et al., 2006; MacDougall et al., 2007) and constructions of relatedness in the absence of a bio-genetic tie (Strathern, 1992a, 1992b, 1992c; Ragoné, 1994; Franklin, 1995; Hayden, 1995; Carsten, 2004; Becker et al., 2005; Konrad, 2005; Mamo, 2005; Thompson, 2005; Hargreaves, 2006; Harrington et al., 2008; Lesnik-Oberstein, 2008).

A pervading theme in the literature on ARTs has been on barriers to recipients' access to treatment, and reproduction, by virtue of their ability to access the clinic (Corea et al., 1985; Steinberg, 1997; Roberts, 1999; Malin, 2003; Culley et al., 2009). However,

few studies have explored recipients' access to treatment *after* they enter the clinic, by virtue of their access to egg donors. Despite the diverse range of ethnographies that took place in the UK over the 1980s and 1990s (Stanworth, 1987; McNeil, 1990; Stacey, 1992; Strathern, 1992a, 1992b, 1992c; Edwards et al., 1993; Franklin, 1997; Franklin and Ragoné, 1998), few addressed the topic of matching in egg donation (Price, 1997; Konrad, 2005).

Studies that have explored the role of clinicians in the matching process have predominantly been undertaken outside of the UK context of gamete donation (Almeling, 2007; Costa, 2007; Szkupinski-Quiroga, 2007; Kroløkke, 2014; Ariza, 2015; Bergmann, 2015; Deomampo, 2016; Homanen, 2018). An increasing literature has also focused on the secondary analysis of egg and sperm donor profiles (Schmidt and Moore, 1998; Baum, 2001; Kroløkke, 2009; Mamo, 2010; Daniels and Heidt-Forsythe, 2012).

Studies exploring clinicians' views of matching in egg donation in the UK have also been sparse. These studies have predominantly reported variability in clinicians' perceptions and practices of 'ethnic matching' but some coherence in their reluctance to 'transracially' match donors and recipients. This includes studies utilising quantitative surveys (Birdsall and Edwards, 1996; Murray and Golombok, 2000; Human Fertilisation and Embryology Authority, 2005b) and qualitative methods (Price, 1997; Konrad, 2005; Campbell, 2007; Klotz, 2014).

Studies on matching have typically focused on recipients' preferences for egg donor characteristics, often outside of the clinical context. Some studies have used quantitative methods (Klock et al., 1994; Lindheim and Sauer, 1998; Lindheim et al., 2000; Broderick and Walker, 2001). The majority of qualitative studies on matching have been undertaken in transnational and international contexts of egg donation,

including India, Mexico, USA, Israel, Romania, Spain, Finland, Czech Republic and Thailand, which had low regulation and a high supply of donors (Nahman, 2006; Whitakker and Speier, 2010; Becker, 2000; Fogg-Davis, 2001; Almeling, 2007; Szkupinski-Quiroga, 2007; Bergmann, 2011, 2015; Daniels and Heidt-Forsythe, 2012; Kroløkke 2014; Deomampo, 2016, Schurr, 2016; Homanen, 2018).

Qualitative studies exploring recipients' preferences for egg donor characteristics and information about donors in the UK have been few and far between (Ahuja et al., 1997; Konrad, 2005; Stuart-Smith et al., 2012; Braverman and Frith, 2014; Hudson and Culley, 2014; Klotz, 2014; Zadeh et al., 2016a). Recipients' selection of *sperm* donors has received more in-depth theoretical attention, particularly in contexts of heterosexual, lesbian and single parent reproduction (Hayden, 1995; Jones, 2005; Nordqvist, 2010; Mamo, 2010). The majority of researchers exploring matching have theorised recipients' selection of donors as a kinship practice (Becker, 2000; Becker et al, 2005; Jones, 2005; Konrad, 2005; Mamo, 2005, 2007; Thompson, 2005; Nordqvist, 2010; Klotz, 2014; Bonaccorso, 2009; Strathern, 1992a, 1992c).

Using a kinship studies framework, these scholars have generally sought to explore to what extent matching practices reinforce or challenge a normative ideology of the nuclear family and how recipients, in the absence of a biogenetic tie with their child, construct kinship relatedness. These studies have highlighted the normative importance of matching for resemblance and the strategies that recipients used to foreground or minimise different aspects of genetics, nature, culture, 'ethnicity', race, relatedness and resemblance in order to do, and display, kinship (Hayden, 1995; Becker et al., 2005; Konrad, 2005; Mamo, 2005; Thompson, 2005; Hargreaves, 2006, Harrington et al., 2008; Cadoret, 2009; Nordqvist, 2010).

In the literature, there has also been a significant emphasis also on matching as a consumer practice. Here, researchers have argued that recipients are consumers who seek to enhance the characteristics of their child by selecting, and often paying for, donors according to their ideal-type preferences, fertility providers are depicted as predominantly commercial businesses which sell donors to recipients and ‘broker’ egg donors, and donors are described ‘vendors’ who sell their eggs in return for money, thus commodifying reproduction and kinship (Becker, 2000; Sharp, 2001; Almeling, 2007; Mamo, 2010).

Some researchers have argued that rather than seek to ‘match’ their own characteristics, recipients selected donors with characteristics which were ‘different’, and perceived as ‘better’, than their own characteristics, as a way of “enhancing” their “family qualities” (Birenbaum-Carmeli and Carmeli, 2002; Mamo, 2005; Nahman, 2006; Nordqvist, 2010; Deomampo, 2016). In this respect, researchers have argued that matching is a consumer practice, where recipients select donors with characteristics which mirror dominant “cultural understandings of physical and cultural power” as a way of increasing the ‘social health and well-being’ of their child (Mamo, 2005). Situating matching as both a consumer practice and a kinship practice, Mamo (2005) has argued that lesbian couples selection of sperm donors in the US constitutes a “biomedicalization of kinship”. Like scholars exploring matching as a kinship practice and as a consumer practice, Mamo (2005) argued that the recipients negotiate nature and culture in complex, co-constitutive ways (Strathern, 1992b; Hayden, 1995; Franklin, 1997; Becker, 2000; Thompson, 2005; Mamo, 2005).

The relatively large literature on matching in transnational contexts of egg donation often touch upon the ‘push’ and ‘pull’ factors which have led recipients to travel abroad for egg donation. Scholars of this literature highlight the constraints in

recipients' home countries which led to them go abroad, including availability of donors and waiting times for treatment (Bergmann, 2015; Hudson and Culley, 2011).

A key theme in this literature has been the stratification of reproduction through the reproduction of whiteness, where recipients travel to countries that they associate with having desirable donors, or rather desirably white donors, and clinics specifically recruit such donors to meet this demand (Nahman, 2006, 2011; Whitakker and Speier, 2010; Cooper and Waldby, 2014; Kroløkke, 2014; Bergmann, 2015; Deomampo, 2015; Schurr, 2016; Homanen, 2018). Scholars have revealed how reproduction is stratified through 'racial', ethnic, class and geographical lines, whereby recipients of donor eggs are often white women from wealthy countries whereas those providing donor eggs are often women from low-income backgrounds (Whitakker and Speier, 2010) and sometimes minority ethnic women (Deomampo, 2016).

The above studies have typically explored the movement of recipients from highly regulated contexts of ARTs to less regulated, commercialised, countries. However, few studies in the UK have explored how recipients have navigated the constraints of the UK clinical context when having treatment in the UK, rather than the impact of these constraints on seeking treatment abroad. This lack of attention, to matching as a medicalised practice, is surprising.

1.2.3 Rationale for this Study

Regulation around Matching

In the UK, egg donation is organised around a regulatory framework. The macro organisation of matching in the UK sits in between matching framework extremes. In the USA and India, for example, matching is organised around the free-market (Becker, 2000; Thompson, 2005; Almeling, 2007; Deomampo, 2016). In Spain and

Finland, there is legislation specifying that clinicians have a mandatory duty to match the ‘ethnicity’ and physical characteristics of donors and recipients (Kroløkke, 2014; Bergmann, 2015; Homanen, 2018). Although there has been no specific legislation pertaining to matching in the UK, the regulation of matching has taken place through policy, the nature of which has changed over time.

Changes in Policy

Between 1990 and 2006, the Human Fertilisation and Embryology Authority (HFEA) specified that clinicians must match donors and recipients by CMV status, ‘physical characteristics’ and ‘ethnicity’, and prohibit recipients from choosing a donor of a different ‘ethnicity’ to themselves (HFEA, 2003). Between 2007-2014, there was a period of policy absence on matching in which matching was left entirely to clinicians' discretion (HFEA, 2007). From 2014 to the present day HFEA guidance stipulates that clinicians are no longer required to ‘ethnically match’ donors and recipients and that, if recipients are willing, clinicians can offer them a donor of a different ‘ethnicity’ (HFEA, 2014a).

The qualitative studies and commentaries on the HFEA ‘ethnic matching’ policy predominantly took place before 2007, when prescriptive HFEA policy on matching was in place (Millns, 1995; Culley, 2005; Campbell, 2007; Wade, 2007). However, no one has yet fully explored the implications of the removal of this policy for the organisation of matching and for the perceptions, experiences and practices of clinicians and recipients within the matching process. Neither has there been sufficient analysis of the implications of matching policy for clinical autonomy, for recipient agency and for the reproduction of families. This study was undertaken during the period of HFEA policy absence on matching, in which matching was left to clinical discretion.

The Wider Context

The predominant model of donor allocation in egg donation and the framing of ‘ethnic matching’ in egg donation are particularly topical because of their resonance with other areas of healthcare and reproduction, such as organ donation and adoption, particularly in relation to the semantics of supply and demand and the role of ‘race’ and ‘ethnicity’. In organ donation, the ‘ethnic matching’ of donors and recipients has had important implications for Black and Minority Ethnic (BME) patients. Despite having a relatively higher need for donor organs, the practice ‘ethnic matching’ and a shortage of BME organ donors has meant that BME recipients typically wait longer to be matched with a donor (Higgins and Fishman, 2006; Malek et al., 2011).

In the field of adoption, the topic of ‘ethnic matching’ has also been subject to much debate (Charles et al., 1992; Gaber and Aldridge, 1994; Rushton and Minnis, 1997; Kirton, 2000; Patel, 2007; Ridley et al., 2010). Here too, BME children are reported as being overrepresented in the care system and wait longer for an adoptive match than their white counterparts. This disadvantage has been perpetuated by a shortage of BME adopters and by regulation stipulating the ‘ethnic matching’ of adopters and adoptees. The implication for BME children, that they remain in the care system rather than be placed with a white adoptive couple, has led to reconsideration of ‘ethnic matching’ as in the best interests of the child.

Debates about ‘ethnic matching’ in adoption have centred on legislative welfare of the child concerns and have been implicated in wider political and socio-historical debates about ‘race’, ethnicity, the state and reproduction (Kirton, 2000). Unlike in the context of organ donation, where racialised ethnicity has been used as a marker for genetic attributes and genetic comparability (Kierans and Cooper, 2013), debates about ‘race’/ethnicity in adoption have centred on ethnicity as a cultural attribute and

cultural compatibility (Kirton, 2000). In both of these contexts, the racialisation of matching and the cultural production of the 'ethnic donor' (Kierans and Cooper, 2012) have led to a professional and cultural discourse of BME communities being 'selfish', 'ignorant' and needing to be 'educated' (Rozon-Solomon and Burrows, 1999; Callender and Miles, 2010), in addition to stratifying BME individuals access to resources.

The 'ethnic matching' of donors and recipients in UK egg donation resonates with the issues outlined above for organ donation and adoption. Here too, the imposition of 'ethnicity' as a matching criterion, particularly in the context of a shortage of BME donors, has been criticised for restricting BME recipients' access to the majority of (white) donors, and to treatment (Millns, 1995; Culley, 2005; Campbell, 2007), and for embodying a sense of social engineering / eugenics in the racialised reproduction of families (Roberts, 1999; Campbell, 2007; Fogg-Davis, 2001; Szkupinski-Quiroga, 2007). Here too, 'ethnic matching' is framed as a welfare of the child concern in policy and clinical discourse (Culley, 2005; Campbell, 2007; Wade, 2007), except here, unlike in adoption, 'ethnicity' is conceptualised as a racialised characteristic, i.e. as a proxy for phenotype and a genetically inheritable attribute.

The geneticisation (Lippman, 1991) of 'race' in this way is particularly alarming given the fact that 'race' is a socio-political construct which has been discredited as having an scientific or genetic basis (Lewontin, 1992; Omi and Winant, 1994; Bradby, 1995; Hall, 2000; M'Charek, 2008), the history of state intervention into 'race' and reproduction (Stoler, 1995; Roberts, 1999) and the use of 'racial' categories as mechanisms of othering, oppression, discrimination (Ahmad and Sheldon, 1992; Omi, 1997; Karlsen and Nazroo, 2006; Wade, 2010; Omi and Winant, 1994; Du Bois, 1994). Policies and practices of 'ethnic matching' in reproduction are particularly contentious at the current time, where the sharp rise in mixed ethnicity families is

challenging traditional pre-conceptualisations about 'race' and reproduction and assumptions about kinship and resemblance (Patel, 2009; Aspinall and Song, 2013).

The Research Focus

Given differences between the context in which matching takes place, the existing theoretical frameworks used to understand matching in egg and sperm donation cannot be simply transposed onto the UK context. Little is known empirically about how matching is organised and undertaken in the UK context of egg donation, in which matching has typically been left to clinical discretion. Scholars have called for researchers to explore the UK context of matching in egg donation further, highlighting the need to explore how clinicians classify donors' characteristics and allocate donors to recipients (Culley, 2005; Hudson, 2015) and how the clinical context impacts recipients' preferences for donor characteristics (Braverman and Frith 2014; Zadeh et al., 2016a).

Given the paucity of research studies on matching in the UK, and the often peripheral attention given to matching in studies on gamete donation, the aim of this study was to put matching at the centre of research, i.e. the central focus. Understanding how matching takes place in the context of UK egg donation will also enable insight into to what extent current theorisations of matching hold in the UK context and/or which other concepts might be drawn upon to understand the peculiarities of matching in the UK context. Contrary to common depictions in the literature, which frame matching as a practice (of donor selection or donor allocation), for the purposes of this study matching is defined as a process which can be broken down into 6 interdependent stages.

These comprise: (1) Classification of donor characteristics (2) Classification of recipient characteristics and recipient preferences for donor characteristics (3)

Management of the recipient waiting list (4) Allocation of donors to recipients by clinicians (5) Offering of donors to recipients by clinicians (6) Recipients' acceptance or refusal of offered donor(s).

Research Questions and Methodology

Based on the review of literature outlined above (and fieldwork) the aim of this research was to explore how donor-recipient matching in egg donation is organised in 2 UK fertility clinics. This involves exploring 4 sub-questions, which will frame the empirical chapters (5-8) of this thesis:

- How do clinicians classify donors and recipients into categories?
- How do clinicians allocate donors to recipients?
- How do recipients express and negotiate their preferences in the context of the clinic?
- How do recipients negotiate accepting/declining donors they are matched with?

This study employs frameworks of (bio)medicalisation, stratification and racialisation to understand the organisation of matching in the UK and the perceptions, practices and experiences of clinicians and recipients within this. This will include exploring the extent to which matching is medicalised compared to common depictions of matching as commercialised and how reproduction and (bio)medicalisation are stratified through matching. In doing so, my aim is to show how a theorised understanding of matching requires consideration of local context and critical examination and reflective application of the theoretical concepts employed to explain matching elsewhere.

The methodology employed is significant to the aims of this study. Because of the nature of matching as a backstage activity (Goffman, 1959) and a clinic-mediated activity (Price, 1997; Konrad, 2005; Klotz, 2014) an ethnographic approach was considered to be the most appropriate method for understanding the organisation of matching and the roles of clinicians and recipients within the matching process. Understanding how matching is organised and practised in the UK context of egg donation can have significant implications for policy makers, clinicians, donors, recipients and donor-conceived persons, and reproduction and society more generally.

1.3 Personal Motivation

I chose the topic of matching in egg donation because I thought it was intellectually exciting. The year before starting this PhD I had just finished an MSc in Medical Sociology, which introduced me to concepts of and debates within ‘medicalisation’, ‘race’ and ethnicity, healthcare inequalities, the social construction of health and illness, the organisation of healthcare, reproductive technologies, medical power and patient agency, all of which I found invigorating. A friend and I were talking about transracial matching in adoption before I chose to study matching, and ‘ethnic matching’, in egg donation. He asked me, ‘Why is it so wrong for a black woman to adopt a white baby but okay for a white woman to adopt a black baby?’

I was confused, and slightly uncomfortable. Something in what he said that rang true with me, but I wanted to pretend that I didn’t understand the question. I started talking about the semantics of the ‘supply’ of adopters vs. the ‘demand’ by adoptees. I think that feeling of confusion, and discomfort, has been one of the motivators for choosing this topic. The topic of ‘matching’ in family building seemed to reveal some of the complexities underlying traditional notions of ‘race’ and reproduction, and the role of

the state, the medical profession, the market and individual agency within this. I had originally planned to compare ‘ethnic matching’ in reproduction across gamete donation and adoption. However, I soon came to realise that this topic appeared to make up two, if not three, separate theses.

As I started to explore the topic of matching in the literature I realised that hardly any studies had focused on matching in the UK context of gamete donation compared with adoption, and so I decided that this would be an interesting and novel area to explore. Upon further exploration, I decided to focus on egg donation, rather than sperm donation, predominantly because of the lack of literature on the former and because of the differential organisation of egg donation and sperm donation in most fertility clinics at the time (e.g. many clinics had ‘outsourced’ sperm donation so that recipients chose their own sperm donor from a provider in Denmark or the USA).

Until 2006, there was a policy in the UK which specified that gamete donors and recipients should be ‘ethnically matched’ by fertility providers. I was intrigued. Why should the state determine the types of families that could be reproduced through gamete donation, and what did this policy say about wider societal values? What was the role of the medical profession within this? What did recipients of donor gametes think about clinicians choosing a donor them? And how did we find ourselves in a situation where the state was not only biologising ‘ethnicity’ but seeking to reproduce racial hierarchies through reproduction, again?

This policy was removed in 2006, but having been introduced to the topic, I could not help but see ‘ethnic matching’ in reproduction everywhere, e.g. in the literature and in advertisements for fertility treatments, on dating websites, and even when walking through the street and contemplating what makes me assume that particular individuals that I saw together were related (aside from their interactions). Although

my interest was initially sparked by ‘ethnic matching’ in egg donation, the paucity of empirical work on matching led me to broaden this scope to explore the organisation of matching in UK egg donation more generally. I felt that this was the gap that needed to be addressed.

1.4 Structure of Thesis

This thesis aims to provide an in-depth, ethnographic, exploration of the organisation of matching in the UK clinical context of egg donation, a topic that has received little empirical attention in the UK to date and which has not been the focus of ethnographic inquiry. The thesis is presented in 8 chapters, including the current introduction to the thesis.

Chapter 2 reviews the relevant literature relating to matching and the main theoretical concepts drawn upon in this study, providing the theoretical background to important concepts and to the generation of the research questions for this thesis. This will explore theoretical frameworks of medicalisation, biomedicalisation, racialisation and stratification and how these have been applied to reproduction through ARTs. Chapter 3 outlines the methodological approach of ethnography as it was employed for this study, including the methods of data collection, sampling, recruitment and data analysis. Chapter 4 explored the wider regulatory context and immediate clinical context of matching and outlines the stages comprising matching as a process; this chapter provides the background context for the empirical chapters to follow. Chapters 5-8 present the empirical findings of this study.

Chapter 5 presents clinicians’ formal, informal and implicit classification of donors and recipients into different categories for the purpose of donor allocation, including donors’ and recipients’ ‘ethnicity’, physical and social characteristics, recipients’

preferences for donor characteristics and recipients' practices of accepting and declining donors. Chapter 6 looks at how clinicians allocated donors to recipients and the factors that shaped their decision-making. Chapter 7 explores recipients' preferences for donor characteristics within the context of the clinic and the types of donors they were willing, and unwilling, to accept as well as their preference for donor information. Chapter 8 focuses on recipients' practices of declining and accepting donors that they were matched with, including how recipients negotiated the constraints of the clinical context.

Chapter 9 presents the conclusions of this study in relation to the research questions. This chapter brings together the key findings of the study and the key contributions it makes. In it, recommendations are made for policy, practice and future research and the limitations of the study are discussed.

Chapter 2: Literature Review

2.1 Introduction

This chapter discusses the literature framing this study. The first part of this literature review focuses on the theoretical frameworks of medicalisation and biomedicalisation as applied broadly to healthcare and the concept of racialisation. Attention will then be given to relevant theorisations of reproduction in relation to Assisted Reproductive Technologies (ARTs) including: stratified reproduction, the (bio)medicalisation of reproduction, commodification of reproduction, technologisation of reproduction, stigma and infertility and the accomplishment of kinship through the clinic. Focus will then be paid to the existing literature on donor-recipient matching in gamete donation and how the gaps in this research shaped the research questions for this study.

2.2 Overarching Theoretical Frameworks

2.2.1 Medicalisation Theory

A key interest guiding medical sociologists until the late 1980s was the origins, persistence and social consequences of medical autonomy (Gabe et al., 2004). The concept of “medicalization” was framed by Zola (1972) to theorise the extension of medical jurisdiction, authority, and practices into increasingly broader areas of people's lives.

‘Medicalisation’ refers to a process where everyday life events become defined and treated as medical problems, requiring medical intervention (Conrad, 2007: 4). Medicalisation has traditionally been associated with the expansion and reification of

medical jurisdiction, dominance and control over behaviour and events which were perceived as being ‘undesirable’, ‘pathological’ or ‘deviant’ (Zola, 1972; Illich, 1977; Conrad and Schneider, 1992a), such as alcoholism and obesity (Salant and Santry, 2006), as well as ‘normal’ and ‘natural’ events, such as pregnancy, childbirth (Oakley, 1984; Petchesky, 1987; Davis-Floyd, 1993), and more recently, infertility and reproduction (Becker, 1992; Whiteford and Gonzalez, 1995; Franklin and Ragoné, 1998; Teman, 2003; Greil et al., 2011; Bell, 2016).

The notion of medicine as an agent of social control was first developed by Parsons (1951) through his conceptualisation of the “sick role”, where an individual enters a period of socially sanctioned deviance which is defined and policed by the medical profession. According to this functionalistic conceptualisation, clinicians have legitimate sanctioned authority as knowledgeable, honest and financially disinterested parties and patients have ascribed rights and obligations, part of which is to seek and follow medical advice. According to Conrad and Schneider (1980b), medicalisation can happen at three distinct levels: the conceptual level (defining a problem as medical), the institutional level (where medical intuitions adopt a medical approach to a problem) and the interactional level (where treatment is sought and a problem is defined/approached as medical).

According to Conrad (2007), medicalisation became the dominant institution of social control, surpassing the role of the church, the family and the state, through its ability to re-define certain categories of ‘deviant’ and ‘natural’ behaviour as being a medical problem rather than a moral problem. This entailed a re-conceptualisation of certain individuals who were regarded as deviant from being ‘bad’ to being ‘sick’ (Conrad and Schneider, 1980a). The main focus in the medicalisation literature has been on the roles (and dominance) of the medical profession and on the role of the lay population in bringing about medicalisation (Ballard and Elston, 2005: 236), in which emphasis

has traditionally been given to the high degree of professional authority, autonomy and dominance enjoyed by the medical profession in society (Zola, 1972; Freidson, 1970; Conrad, 2007), with some earlier theorists emphasising the medical imperialism underlying medicalisation (Illich, 1975). In contrast, the role of patients in the medicalisation thesis has traditionally been depicted as that of ‘passive’ ‘docile’ and ‘vulnerable’ patients, who lose control over what happens to their own body, are subject to assessment, diagnosis and treatment, all of which they are expected to unquestioningly comply with (Lupton, 1997).

The medicalisation thesis has been criticised on a number of levels. Feminist critiques of medicalisation have highlighted its patriarchal nature, where it is women who are especially vulnerable to the process of medicalisation and men who exercise them (Steinberg, 1997; Conrad, 2007). The relationship between the medical profession and the state has also been theorised in relation medical autonomy, where state regulation of medicine can at once can sanction clinicians’ autonomy and dominance (MacDonald, 1995; Moran, 1999; Johnson, 1982; Salter, 2004; Freidson, 1970) and constrain it (Freidson, 1970; Larkin, 1993). Since the 1990s, attention in the sociological literature has turned to wider changes which have challenged the medical profession’s deep-seated position of power and changed the nature of the patient role (Gabe et al., 2004).

These critiques argue that modernity, the era through which medicalisation was theorised, has been superseded by different social orders, including postmodernity/late modernity, neo-liberalism, individualisation and risk society (Giddens, 1990; Beck, 1994; Ballard and Elson, 2005). As such, some scholars argue that the concept of medicalisation is no longer suited to the current era and should be abandoned (Rose, 2007) and replaced with concepts more able to explain these wider frameworks, such as “Pharmaceuticalization” (Abraham, 2010) or

“Biomedicalization” (Clarke et al., 2010). Of these, the concept of ‘biomedicalisation’ is most suited to understanding ARTs, which have been posited as epitomising biomedicalisation (ibid), and provides a useful synthesis of the concepts and changes to medicalisation theory which are relevant for this thesis. The UK-English spelling of these theories (i.e. the use of “s” rather than “z”) has explicitly been chosen to denote the importance of considering how they might be applied to the UK context as well as being a preferred grammatical choice.

2.2.2 “Biomedicalization” Theory

According to Clarke et al. (2003), the increasing use of ‘technoscientific’ innovations and the commodification of healthcare more generally have not only been co-constitutive of medicine but have led to the transformation of the very nature of medicine, or biomedicine, itself. As such, they argue that medicalisation theory is unable to capture the nuanced power dynamics and complex ways in which individuals, as agents of power, engage with biotechnologies and in which the market shapes relations and practices of healthcare. Instead, Clarke et al. put forward the term “Biomedicalization”, which they argue is more suited to explaining some of issues previously encompassed under the umbrella of the medicalisation thesis. According to Clarke et al. (2003), biomedicalisation refers to:

“The increasingly complex, multi-sited, multidirectional process of medicalization, extended through and reconstituted through new social forms of highly technoscientific biomedicine” (Clarke et al., 2003: 161)

Biomedicine, Clarke et al. argue, has been reorganised “not only from the top down or the bottom up but *from the inside out*” (2003; 162, original emphasis). They argue that biomedicalisation is “mutually constituted” and “manifest” through five interactive

processes which began in the mid-1980s. These comprise: (1) the politico-economy of biomedicine, (2) a focus on health (rather than illness) and the elaboration of risk and self-surveillance biomedicines, (3) the increasingly (co-constitutive) technological and scientific nature of biomedicine, (4) transformations in the production, management, distribution and consumption of biomedical knowledges and information, and (5) the transformation of bodies and the production of new individual and collective techno scientific identities (rather than medical labels).

Echoing wider critiques of the medicalisation thesis (Haug, 1973, McKinlay and Arches, 1985; Rose, 2007) Clarke et al., (2010) argue that the above processes have led to a transformation of the 'patient' role and to a decline of medical autonomy and dominance (Busfield, 2017). They argue that the main driver for medicalisation is no longer the medical profession, something which has been generally agreed upon by scholars of medicalisation (Conrad, 2005; Busfield, 2017; Ballard and Elston, 2005), and that the above processes, which have curbed the expansion of medical jurisdiction, and even retracted it (Clarke et al., 2010).

A central tenant of the thesis is that there has been a shift in focus away from the treatment of disease and illness towards the commodification of health and well-being and that as part of this shift there has been a transfer of the medical profession's dominance to multiple sources of agency through an increase towards 'technologies of the self' and governmentality (Foucault, 1988; Rose, 1996, Turner, 1997; Clarke et al., 2003: 162). Thus, health becomes both a commodity *and* moral obligation 'to be fulfilled through improved access to knowledge, self-surveillance, risk assessment, the treatment of risk, and the consumption of appropriate biomedical goods and services' (Clarke et al., 2010: 162). Clarke et al., (2003) argue that in the 'biomedicalized' era there is no longer need to pathologise the body for medical

intervention; rather one always has to manage being 'at risk' through self-surveillance and governmentality.

According to Clarke et al., (2003) risk and self-surveillance mutually construct each other. Thus individuals are 'always at risk' to some degree (Giddens, 1990; Beck, 1992; Lupton, 1999) or occupy the role of the "worried well", where risk, rather than merely illness, becomes the object of intervention and treatment. Thus it is impossible not to be "at risk" as the rhetoric of 'biomedical governmentality' means that individuals feel compelled to inscribe themselves with technoscientific identities which give them access to previously unavailable identities, e.g. infertile women becoming mothers (Clarke et al., 2010: 64). According to Roth (2010: 471) risk has become a 'proxy for moral discourse', where the use of risk assessment techniques by governments, which identify people as 'at risk', serve as a justification for bringing people under social control.

Clarke et al., (2010) argue that whilst health becomes more biomedicalised through risk, self-surveillance and routine screening it simultaneously becomes "less medicalized", which they define as a shift in responsibility from the medical profession to the individual. This echoes the view of other scholars who argue that an increase in self-surveillance and care can constitute de-medicalisation at an interactional level (Ballard and Elston, 2005). One of the most potentially fruitful concepts in the biomedicalisation thesis is that of "stratified biomedicalization" (Clarke et al., 2010). According to Clarke et al. (2003: 170) the concept "stratified biomedicalization" refers to the persisting "cooptative and exclusionary tendencies" of medicalisation which:

"Become increasingly complex, and new modes of stratification are also produced- not just based on inability to pay [...] Thus, Even as biomedical technologies extend their reach into ever more spaces, many people are completely bypassed, others impacted unevenly" (Clarke et al., 2003: 170).

Thus, new modes of inequalities are produced and old ones are reinforced. Clarke et al., (2010) seek to incorporate the uneven, heterogeneous and multidirectional nature and effects of biomedicalisation, through which wider societal inequalities are reproduced in the field of biomedicine according to familiar divisions of ‘race’, class, gender and other ‘sites of inequality’. Pertinent here are the two framings of stratification that Clarke et al. (2010) incorporate and elaborate on in their formulation of stratified biomedicalisation; Ehrenreich and Ehrenreich’s (1978) ‘critical elucidation’ of the dual tendencies of medicalisation as ‘cooptative’ and ‘exclusionary disciplining’ and Ginsburg and Rapp (1995b) framing of “stratified reproduction” (which will be elaborated on further below).

Whilst cooptive medicalisation refers to the traditional use of medicalisation and has predominantly included middle/upper class white women, exclusionary/disciplinary medicalisation refers to the ways in which medicine erect barriers to access and targets particular segments of the population for particular types of biomedicalisation, and have been prevalent with BME and poorer women (Clarke et al., 2010; Shim 2010; Bell, 2016). The main focus of stratified biomedicalisation in Clarke et al.’s (2010) framing of the concept has been on individuals’ access to healthcare, and ARTs, which are “imposed, made accessible, and/or promoted differentially to different populations and groups”, predominantly based on ability to pay (Clarke et al. 2003: 181).

Thus, stratified biomedicalisation is closely linked to the commodification of health. Other ‘dividing practices’ drawn up by the authors include ‘risky’ or ‘good’ genetics, ‘deserving’ and ‘compliant’ behaviours and valued demographics (e.g. income and insurance). The reproduction of wider inequalities is at the heart of stratified biomedicalisation. According to Clarke et al. (2010: 21) inequalities “dwell in the

very structures and processes of biomedicalization [...] Thus biomedicalization carries within itself the ideological, social, and cultural infrastructures that support and maintain racial and class inequalities”.

Criticisms of Biomedicalisation Theory

“Biomedicalisation theory” has itself been subject to numerous critiques. This includes criticisms regarding the overlap of phenomena across biomedicalisation and medicalisation (Conrad, 2013), the era to which the recent thesis lays claim (Busfield, 2017), the broad theoretical framework used to describe biomedicine (Williams et al., 2012) and about the consumer and rational agency accorded to patients (May 2007; Ballard and Elston, 2005). Conrad (2005) has argued that the rise of consumerism and biotechnologies are part of an “important shift in the engines that drive medicalization”, and not apart from medicalisation.

Conrad (2005) too acknowledges that the medical profession now has an insubordinate role in the expansion of medicalisation but argues that demedicalisation only occurs when a problem is no longer defined in medical terms and medical treatment is no longer deemed appropriate (Conrad, 1992). Thus Conrad (1992) and others have argued that medicalisation and medical dominance are not synonymous (Ballard and Elston, 2005: 233). More recently scholars have argued that the concept of medicalisation still has value but that the thesis of the 1970s is more complex, ambiguous and contested; they argue that we need to consider the contexts of that are conducive to medicalisation, or not, and the different forms of medicalisation, as well as the roles of the ‘active patient’ and ‘medical dominance’ (Busfield, 2017; Ballard and Elston, 2005).

As highlighted by Herzig (2015: 83), “the concept of “stratified biomedicalization” on its own does not offer much in terms of delineating the processes of mechanisms of

stratification”. Missing in biomedicalisation theory are understandings of how ‘race’ and ethnicity interact with biomedicalisation, as acknowledged by Clarke et al., (2010). Despite Clarke et al., (2010) contention that stratified biomedicalisation goes beyond ability to pay and involves ‘new modes of stratification’ they offer few examples outside of the commercialised context of ARTs to develop this. To these criticisms I would add that one needs to consider the extent to which the wider neo-liberal framework of healthcare in the USA is applicable to other contexts of biomedicine where there is a different healthcare system and political-economic context (Larkin, 1993; Moran, 1999; Gabe et al. 2004).

Although biomedicalisation theory provides some useful concepts and an insightful synthesis of changes to (bio)medicine in recent decades, I agree with recent scholars who argue that it does not necessarily constitute a separate theory in and of itself (Conrad, 2005; Busfield, 2017; Ballard and Elston, 2005). Following Bell and Figert (2015), I will use the pre-fix the term ‘bio’ in brackets, where relevant, when using the theory to denote these limitations.

2.2.3 Racialisation

‘Race’ is a socio-political construct that refers to the grouping of people based on perceived phenotypical variation and which is assumed to be grounded in biology/genetics (Jenkins, 2008) but can also incorporate cultural differences as part of the ‘natural’ differences between ‘races’ (Wade, 1995). Historically, ‘race’ and ‘racial categories’ have been used to differentiate between people as a mechanism for legitimating systems of slavery, colonialism and eugenics (Du Bois, 1994; Stoler, 1995; Malik, 1996; Rex, 1988; Karlsen and Nazroo, 2006; Omi and Winant, 1994). Blumenbach’s ‘racial’ classification in the late 1700s has shaped modern day

conceptualisations of 'race' and ethnicity, in which he distinguished between 5 different 'races' of human being: Caucasian, Mongolian, Ethiopian, American and Malay.

In the 1950s, following historic and then recent atrocities based on racist conceptualisations, social and biological scientists demonstrated that 'race' does not exist, in scientific terms at least, by showing that there is more genetic variation between individuals in 'racial' groups than variation within 'racial' groups (Lewontin, 1972; Ahmad, 1993; Omi and Winant, 1994; Bradby, 1995; Wade, 1995; Back and Solomos, 2000; Hall, 2000; M'Charek, 2008).

Whilst there is general consensus amongst scholars that "race" is a social construct and does not have a biological reality (Hall, 2000), hence the common use of inverted commas around the term, there is also acknowledgement that the term has a legal, social, political and historical reality with important material, social, economic and political consequences (Wallman, 1988; Omi and Winant, 1994; Guillaumin, 1999; Appiah, 2000; Gunaratnam, 2003; Szkupinski-Quiroga, 2007). Thus scholars generally agree that the use of terms such as 'racialisation' and 'racism' but are more ambiguous about to what extent to retrain the concept of 'race' (Miles, 1989; Omi and Winant, 1994; Gilroy, 2000a, 2005b; Hall, 2000).

The term "ethnicity" emerged in sociological writings in the 1960s (Furseth and Repstad 2006) was introduced to draw attention away from racialised ideas of immutable differences and external categorisation based on phenotypical differences (Chapman, 1993; Nazroo, 1997). "Ethnicity" depicts collective identities with a shared history or culture, common geographical origin (nationalism), common language, religion or set of experiences and emphasises the flexible and self-defining nature of classification (Bulmer, 1986; Wallman, 1986; Omi and Winant, 1994;

Bradby, 1995; Smaje 1996; Aspinall, 1997; Furseth and Repstad 2006). There is also debate around these elements of 'ethnicity' and what they mean, and whether to include physical appearance as a marker of ethnicity (Modood et al., 1997).

Despite 'ethnicity' existing to rectify the earlier misgivings of 'race', in practice, it is commonly conflated with 'race' (Wallman, 1988; Smaje, 1996; Hall, 2000) or used as a euphemism for 'race' (Gilroy, 2000b). Indeed, the term 'race' has remained in general use, policy, popular discourse and healthcare. There is also recognition that ethnic categories are generally deemed to be a poor proxy for understanding the complexities of human variation and instead provide the basis on which particular groups become racialised. Racialisation is a social and political process through which groups of people with shared migratory, ancestral histories, skin colour, shared languages and in some cases, religions, become 'marked' as a racial group which is assumed to share a biological basis (Miles, 1989). According to Miles (1989:75) racialisation refers to 'those instances where social relations between people have been structured by the signification of human biological characteristics in such a way as to define and construct differentiated social collectivities'.

In healthcare, the main focus of the literature has been on patterns of ethnic inequalities in health and access to healthcare (Bhopal, 1990, 2007; Ahmad, 1992; Bradby, 1995; Smaje, 1995; Modood et al., 1997; Nazroo, 1997, 1998; Nazroo and Williams, 2006; Clarke et al., 2010; Shim, 2010) and the relationship between class and ethnicity has been highlighted to varying degrees (Rex, 1988; Miles, 1989; Nazroo, 1998; Gilroy, 2000). Attention has also been given to healthcare professionals' meaning and use of 'racial' and ethnic terminology and measures for operationalising ethnicity (Sheldon and Parker, 1992; Aspinall, 2005; Karlsen and Nazroo, 2006). The collection and use of 'ethnic' statistics and data is a contentious and contested terrain, including debates about the advantages and disadvantages of

ethnic data collection, the purpose of collection, how categories of identification are created and operationalised and the subsequent utility and interpretation of ethnic statistics (Sillitoe and White 1992; Bulmer 1986; Aspinall 1997).

More recently scholars explored the ways in which ‘race’ has become reinvigorated through developments in genetic technologies, including the Human Genome Project and personalised genetic medicine through which sophisticated technologies are being employed based on old classificatory regimes (Collins, 1999; Duster, 1990; 2005; Rabinow and Rose, 2006; M’Charek, 2008).

In this study the term ‘racial matching’ rather than ‘ethnic matching’ has been chosen because it most accurately reflected the meaning of participants’ accounts. It would have been inauthentic to use ‘ethnic matching’ in inverted commas to relay the ambiguity surrounding its use as ethnicity clearly was not the subject of clinicians’ discourses and practices. The term ‘racial matching’ was also chosen because it was consistent with the terminology used to describe its antithesis- ‘transracial matching’. However, in recognising that ‘race’ does not in fact exist as a scientific construct ‘race’ and ‘racial’ terminology is kept in inverted commas.

Below, I will discuss how reproduction has been theorised in relation to ARTs, particularly in the context of the theoretical frameworks and concepts outlined above.

2.3 Theorising Reproduction

2.3.1 Stratified Reproduction Theory

The concept of ‘stratified reproduction’ emerged with a focus on globalised and transnational contexts of reproduction. The term was originally coined by Shellee Colen in the 1980s from her analysis of the relationship between West Indian migrant

women working as childcare workers for white employers in New York (Colen, 1986). Ginsburg and Rapp (1995b) elaborated Colen's (1986) concept of 'stratified reproduction' in their jointly edited book which explored how women in different societies varied in their experiences of genetic reproduction and child care. Unlike Colen's (1986) original use of the term, which referred specifically to 'social reproduction' (i.e. nurturing) Ginsburg and Rapp (1995b) expanded the concept to include bio-genetic reproduction, in addition to social reproduction.

Like Colen (1986, 1995), Ginsburg and Rapp (1995b: 313) advocate the need to explore how seemingly distinct power relations and contexts (e.g. policy, cultural, economic) shape local reproductive practices. According to Ginsburg and Rapp's definition (1995b: 3) definition, which has subsequently been used by a range of scholars in a range of reproductive contexts, stratified reproduction refers to:

“The power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered . . . [and] arrangements by which some reproductive futures are valued while others are despised”

The prime focus of stratified reproduction has traditionally been on conceptive technologies, such as sterilisation, abortion and birth control (Greil et al., 2011). However, in recent years scholars have applied the concept to Assisted Reproductive Technologies (ARTs) and on women's stratified access to ARTs based on wider divisions of class, ethnicity and sexuality (Mamo, 2007; Culley and Hudson, 2009b; Inhorn et al., 2009; Greil et al., 2011; Bell, 2016), particularly in cases of 'transnational' and 'cross-border' fertility treatment (Kahn, 2000; Nahman, 2006; Twine, 2015). Thus the concept has predominantly been explored within highly commercialised contexts of reproduction where intending parents from wealthy countries travelled to less wealthy countries to access fertility treatment, often leaving

their home countries to escape regulatory constraints (Bergmann, 2011; Culley et al., 2011; Hudson et al., 2016).

The stratification of reproduction is also evident within academic studies on infertility and ARTs, where most studies on ARTs have focused on the experiences of white middle class women, in what Culley et al., (2009: 2) have referred to as a ‘research lacuna’. This has led to a large literature on the ‘reproduction of whiteness’ (Roberts, 1999; Szkupinski-Quiroga, 2007; Cooper and Waldby, 2014; Kroløkke, 2014; Deomampo, 2015; Schurr, 2016; Homanen, 2018).

ARTs have been posited in the literature as a “prime example” of *both* stratified reproduction (Ginsburg and Rapp, 1995b; Inhorn and Fakih, 2006; Inhorn and Birenbaum-Carmeli, 2008) and stratified (bio)medicalisation (Clarke et al., 2010). As the majority of ARTs are privately funded, access is largely restricted to those who can pay, although other barriers may also impede access (Roberts, 1999; Culley et al., 2004; Culley and Hudson, 2009b; Greil et al., 2011; Armstrong and Plowden, 2012).

On the one hand, ARTs have generally been made available to white wealthy women, whose reproduction is ultimately valued and empowered (Inhorn, 2003; Bell, 2016). On the other hand, poor and BME women, who are reported as having a higher prevalence of infertility, are unable to access ARTs or are typically subject to particular types of co-optive medicalisation intended to restrict their fertility and therefore have their reproduction ‘despised’ and disempowered (Roberts, 1999; Inhorn, 2003; Inhorn and Fakih, 2006; Inhorn and Birenbaum-Carmeli, 2008; Culley et al., 2004; Culley et al. 2009; Inhorn et al., 2009; Greil et al., 2011; Bell, 2016).

Women from BME and lower social class backgrounds are more likely to receive medical attention that impedes fertility (like sterilisation and compulsory contraception) and less likely to receive medical interventions which facilitate fertility

(like ARTs), patterns which reflect wider social values about deserving and undeserving mothers (Riessman, 1983; Stoler, 1995; Roberts, 1997; McCormack, 2005; Greil et al., 2011; Inhorn and Fakih, 2006; Inhorn et al., 2009). Thus, as pointed out by Cussins (1998: 73, now Thompson), women are stratified into two groups: “those for whom contraception is available if only they’d use it and those for whom there are infertility treatments”. According to Roberts (1999: 253-254) the disparity between white and black women’s access to ARTs in the US “stem from a complex interplay of financial barriers, cultural preferences, and more deliberate professional manipulation” and are “an extension of their more general marginalization from the health care system” (Culley et al., 2009).

Scholars argue that ‘stratified reproduction’ and ‘a eugenic logic’ (Inhorn and Fakih, 2006) mean that infertility has been seen as a ‘non-issue’ for low income and black women, who have been stereotyped as “hyper-fertile” by the white medical profession and consequently ‘steered away’ from the use of such technologies or discouraged in other ways (Roberts, 1999; Culley et al., 2004 Inhorn and Fakih, 2006; Inhorn et al., 2009). In the UK, structural, linguistic and cultural barriers have also been emphasised over individualistic contributions to such inequalities (such as individual cultural preferences and professional manipulation), and the pervasiveness of racism has been a dominant aspect of these barriers (Culley et al., 2009).

2.3.2 The (Bio)Medicalisation of Reproduction

Early theorising and research on the medicalisation of reproduction was championed by feminist scholars, who saw patriarchy as a key force behind the medicalisation of women’s health. This added an additional dimension of power in medical technologies, between those who invent and use them vs. those upon whom they are

used, particularly in relation to gender (Spallone, 1989). Women are especially vulnerable to the process of medicalisation (Steinberg, 1997; Gabe et al., 2004; Conrad, 2007) where the focus of technological and medical control has not merely been on reproductive bodies but on women's bodies (McNeil 1990) and where the majority of scientists and doctors are nearly always men (Corea et al., 1985; Spallone, 1989, Burfoot, 1990; Steinberg, 1990).

Much of the earlier work on the medicalisation of reproduction focused on the medicalisation of pregnancy and childbirth (Oakley, 1984; Petchesky, 1987; Davis-Floyd, 1993) which provided the "gateway" into work on the 'medicalisation of infertility' and scholarship on ARTs (McNeil, 1990; Annandale and Clark, 1996; Gabe et al., 2004; Conrad, 2007). Before the advent of In Vitro Fertilisation (IVF), female infertility, or involuntary childlessness, was traditionally defined as a natural and social condition, with a social solution, i.e. adoption (Pfeffer, 1993; Szkupinski-Quiroga, 2007). However, the successful development of IVF technology, which also enabled egg donation, meant that infertility could be 'treated', or circumvented, to enable otherwise infertile women access to reproduction. This meant that female infertility came to be re-defined as a medical problem, with a medical solution.

In emphasising an increase in 'technologies of the self' and governmentality (in the Foucauldian sense of the medical gaze and disciplining bodies), Clarke et al. (2010) argue that infertile women may feel obligated to use ARTs as a means of accessing the desired identity of motherhood, which is itself informed by wider social norms and expectations surrounding women and motherhood, i.e. the 'motherhood mandate' (Russo, 1976). This echoes earlier feminist critiques of ARTs which argued that in a context within which motherhood is defined as a natural role for all women (Russo, 1976), childlessness, whether by choice or not, is seen as deviating from this norm and stigmatised (Raymond, 1993; Franklin, 1997). In this context, the

(bio)medicalisation of infertility has meant that women feel “compelled to try” to reproduce through ARTs (Franklin, 1997; Becker, 2000; Clarke et al., 2010).

Radical feminists opposing the use of ARTs argued that these technologies depersonalise and objectify women, turning them into mere body parts (i.e. womb, eggs, hormones) and baby making machines (Corea et al., 1985; Raymond, 1993) through procedures controlled by men which are intended to monitor, control and manipulate aspects of women’s reproductive bodies (Spallone, 1989). Echoing feminist critiques of the medicalisation of childbirth these scholars argue that ARTs have not enhanced women’s reproductive rights but diminished them, turning women from agents of their own reproduction to passive patients whose definitions and meanings of their own experiences are overcome by doctors medical definitions and discourses (McNeil, 1990; Steinberg, 1990; Pfeffer, 1993). However, such critiques have not been without their own criticisms (Riessman, 1983; Petchesky, 1987; Davis-Floyd 1993; Annandale and Clark, 1996).

The subjective role of clinicians as gatekeepers and decision-makers in determining access to infertility services has been the subject of much attention and criticisms (Rose, 1987; Millns, 1995; Price, 1997; Steinberg, 1997; Roberts, 1999; Szkupinski-Quiroga, 2007; Hudson and Culley, 2014). According to Price (1990: 152): “The IVF procedure raises fundamental ethical questions about the control of human reproduction and the grounds for limiting clinical freedom. IVF clinicians and their scientific colleagues cannot legitimately claim any special skills to make ethical and social decisions”.

The gate-keeping role of clinicians in accepting or refusing women as recipients can be seen a mechanism for stratification of reproduction, whereby those with socially or genetically desirable characteristics are encouraged to procreate whereas those who

are deemed socially or biologically ‘undesirable’ tend to be excluded from the reproductive process, e.g. people who use drugs, those with a criminal history, alcoholics, those with genetic disorders (Steinberg, 1990; Robertson, 1991; Roberts, 1999; HFEA, 2003; Mamo, 2005; Almeling, 2007; Szkupinski-Quiroga, 2007; Apel, 2008).

Thus, whilst explicit in the notion of medicalisation is that medical professionals exercise control over the means of reproduction also implicit in such control is the desire towards an ideology of normalisation (Conrad, 2005), specifically in relation to notions of the ideal-type white nuclear heterosexual family (Steinberg, 1997; Campbell, 2007). In other words, the medicalisation of reproduction is concerned with what is normal and pathological, and what is considered normal within the infertility clinic is supported and confirmed by what is considered natural and socially acceptable in society more generally (Spallone, 1989; Steinberg, 1997; Atkinson et al., 2001; Thompson, 2005). As highlighted by Atkinson et al., (2001:9): “what health professionals’ identify as a family, and what counts as knowledge about families (or any one particular family) is socially defined and legitimated”. Therefore, reproduction is not only medicalised but is structurally normalised so that it develops according to the ideology of the traditional nuclear family (Franklin, 1990).

As highlighted by Franklin (1990: 1) what appears to be at stake therefore “is more than helping couples to biologically procreate, it is the necessity for the social and cultural reproduction of specific constructions of parenthood and procreation on which traditional family values and conventional sexual arrangement are predicated”. Studies have found that clinicians judgments about who is a ‘deserving patient’ (Doyal, 1987) or even a ‘deserving parent’ (Malin, 2003) are based on their own ‘idiosyncratic values and personal principles’ (Pennings, 2001) and according to their

own perceptions of patients' relationships, age, sexuality, ethnicity and class (Haimes, 1992; Price, 1997; Steinberg, 1997; Roberts, 1999; Malin, 2003).

In particular, scholars have drawn attention to Section 13(5) of The Human Fertilisation and Embryology Act (1990) which mandates that clinicians take into account welfare of the child considerations before providing intending parents with treatment (explored further in Chapter 4) as an illustration of clinicians' expanding medical jurisdiction (Steinberg, 1990; Millns, 1995; Steinberg, 1997; Malin, 2001, Campbell, 2007).

Section 13(5) has been seen as a prime example of medicalisation in which clinicians have a state-sanctioned role as reproductive gatekeepers (Campbell, 2007; Szkupinski-Quiroga, 2007), although Lee et al. (2014) have argued that this gatekeeping capacity has more of a reality in law than in practice. From their study with 66 fertility clinic staff (including medical and non-medical professionals) Lee et al. (2014) found that clinicians took a "light touch" approach to the application of their duty to consider the welfare of the child which was more a 'box-ticking' and symbolic exercise than judgement of family forms. Instead, they drew attention to the role of other non-medical professionals in taking into account the welfare of the child, i.e. counsellors, and concluded that that medicalization is a "blunt tool" for understanding the complex realities of service provision (Lee et al., 2014: 513). However, like other authors who have focused on legislated welfare of the child considerations Lee et al., (2014) did not specifically question clinicians about matching (Blyth, 1995; Daniels et al., 2016).

Thus the main focus in the literature has been on the role of clinicians as gatekeepers to social and genetic parenthood by virtue of their role in determining whether patients can access treatment (Steinberg, 1997; Mamo, 2005). Less attention however

has been paid to clinicians' role in determining patients' access to treatment by virtue of their access to egg donors (Millns, 1995; Pennings, 2000). Drawing on historical connections between eugenics and medicine and the role of medicine in controlling women's reproduction along racial, sexual and class grounds (Spallone, 1989) radical feminists have argued that the ARTs follow similar patterns of prejudice (Petchesky, 1987; Stanworth, 1987; Spallone, 1989; Steinberg, 1997). Such stratifications are also reflected in Ehrenreich and Ehrenreich's (1978) conceptualisation of the dual tendencies of medicalisation as 'cooptative' and 'exclusionary'.

The (bio)medicalisation of reproduction through ARTs has thus contributed to the 'stratification of reproduction', whereby some categories of people are encouraged to reproduce whilst others are disempowered and discouraged from reproduction (Colen, 1986), and where "inequalities of class, race and gender are reinforced and intensified through stratified systems of reproduction" (Ginsburg and Rapp, 1995b: 98). In addition to medicalisation, concepts of 'commercialisation' and 'technologisation' are central to the (bio)medicalisation thesis and have also been theorised in relation to their impact on reproduction.

2.3.3 Commodification of Reproduction

The emergence of fertility treatment within a 'for-profit' healthcare industry has been central to the development of ARTs in most countries (Mamo, 2010). The majority of fertility treatments are privately funded across the world (with some exceptions, such as in Israel), making egg donation an inherently commercialised practice. Whilst the commodification of healthcare and medicine more generally has shown medicine and health to be a consumer good, particularly in the USA (Conrad, 2005), the commodification of reproduction in particular raises specific ethical concerns because

it involves the creation of life (Strathern, 1992b), although some argue that we should reflexively lay such concerns about the commodification of reproduction to bed (Spar, 2006).

The commodification of reproduction assumes that reproduction (and the people and gametes involved) can be acquired and marketed in the same way as other commodities and consumer goods. Within this context, some sociologists have argued that donors, their characteristics, their gametes, and children conceived through gamete donation have become commodified through the use of ARTs (Overall, 1987; Stanworth, 1987; Pfeffer, 1993; Sharp, 2001; Duster, 2006; Almeling, 2007). This has particularly been the case in unregulated contexts of egg donation, where donors can be paid uncapped amounts for their donation and recipients can pay hundreds of thousands of dollars for treatment (Almeling, 2007; Glennon, 2012).

One of the central debates in literature on gamete donation has been whether the ‘donation’ of gametes amounts to their exchange as an altruistic gift or a commodity (Strathern, 1992b; Tober, 2001; Konrad, 2005; Thompson, 2005). Some researchers have argued that true altruism cannot exist in gamete donation, where the notion of altruism itself is used by gamete agencies and fertility providers as a “secondary commodity” in order to imbue it with higher emotional, moral and economic value (Tober, 2001: 157; Almeling, 2007).

Whilst the predominant concerns of earlier feminists were centred on the transformation of women from being agents of their own reproductive capacities to patients in the reproductive process the enormous growth of the fertility industry has re-focused attention to the role of women as consumers. According to McNeil (1990), the language of consumerism has infused the language of choice in ARTs to such a degree that the idea of women’s choice has now become a ‘consumer idiom’

(Strathern, 1992b) where women's reproductive freedom and rights have been translated into consumer rights and choices (McNeil, 1990; Davis-Floyd, 1993).

2.3.4 Technologicalisation of Reproduction

Whilst the medicalisation of reproduction has fundamentally re-defined the reproductive process through the expansion of medical jurisdiction and social control, this expansion has only been made possible by the use of technologies, or biotechnologies (McNeil, 1990; Conrad and Schneider, 1992b; Conrad, 2013). That is, ARTs involve “the interventions of the natural sciences and the biotechnology industry brought to medicine” (Spallone, 1989: 178), and it is these aspects of science and technology which have received attention from sociological and Science and Technology Studies and feminist scholars of ARTs.

The tension between ‘natural reproduction’ and ‘assisted reproduction’ has been central to discussions about the use of technologies in reproductive processes (Franklin, 1990) and has typically been framed in terms of a ‘woman-centred’ natural approach versus the technological, artificial and consumerist nature of ARTs (Burfoot, 1990; David-Floyd, 1992). According to this dualistic view “what was once regarded as natural- that is, reproducing babies – is now the work of culture, of human-made technologies” (Finkler, 2000: 40; Strathern, 1992c).

Since the mid-1980s/early 1990s scholars began to shift their analytic focus from gender to the field of science and technology (Franklin, 1997; Thompson, 2005; Mamo, 2010) and explore how individuals transformed, accepted or rejected ‘technological scripts’ for their own purposes and at how they understood ‘meaning as conjoined with materiality’ (MacKenzie and Wajcman, 1985; Haraway, 1991; Rabinow, 2005; Thompson, 2005; Mamo, 2007). These scholars have rejected the

natural-technological dichotomy, arguing that these two domains are co-constitutive, rather than separate and oppositional (Haraway, 1991; Rabinow, 1992; Strathern, 1992b; Franklin, 1997; Wade, 2007). Based on the idea of nature and biotechnology as co-constitutive, a number of researchers have looked at the implications of this emergence and the ways in which science and technology have enabled the emergence of new group and individual identities (Haraway, 1991; Rabinow, 1992; Clarke et al., 2003) and new types of relationships (Strathern, 1992b; Franklin, 1997; Mamo, 2005; Thompson, 2005).

The rise of genetic technologies have had particular implications for reproduction and the 'geneticisation thesis', which contends that increasingly "most disorders, behaviours and physiological variations [are] defined, at least in part, as genetic in origin" (Lippman, 1991: 19; Haraway, 1991; Rabinow, 1992; Rapp, 1999; Thompson, 2005; Mamo, 2007; Wajcman, 2009). For example, researchers exploring the impact of ARTs on kinship and the family have drawn on such conceptualisations to understand recipients' constructions of relatedness, as will be outlined further below.

2.3.5 Stigma and Infertility

The concept of stigma has predominantly been developed through the work of Erving Goffman. A stigma refers to a socially ascribed label which deviates from the 'norm', is discrediting, and which reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman 1963: 3). Goffman outlined 3 forms of stigma: "abominations of the body" (physical 'deformities'), "blemishes of individual character" (e.g. homosexuality, unemployment) and "tribal stigma" (stigmatised attributes which are transmitted through family lineage, e.g. 'race', nation, religion).

Drawing on social interactionist perspectives of labelling theory Goffman maintained that stigmatisation is about social perceptions and social relationships rather something inherent in an attribute or person. In this context, the 'normal' and the 'stigmatised' can be seen as *perspectives* rather than people who occupy these categories (Goffman, 1963: 163-4). Goffman argued that a stigma is a 'special discrepancy' between a person's 'virtual identity' (normative assumptions about how people should be) and a person's 'actual social identity' (the actual qualities they possess). That is, a stigma is a 'spoiled identity' which deviates from the norm. When this discrepancy is immediately obvious and visible then a person is 'discredited' and has little control over the disclosure of their stigmatised attribute(s), e.g. a physical deformity. When this discrepancy is present but not immediately apparent then a person is 'discreditable' e.g. a mental illness.

Stigma thus refers to the 'marking' (a taint or blemish) of individuals and groups based on stereotypes about them. A person's stigmatised characteristic(s) can be conceptualised as a person's 'Master Status' (Hughes, 1945) which overrides all other identity categories associated with individuals (Becker, 1963). Goffman (1963) also used the term 'courtesy stigma' to refer to "normal" individuals who associate with stigmatised individuals and share the 'taint' of their stigma by association. Others have developed this concept into terms such as 'associative stigma' and 'stigma by association' (Neuberg et al. 1994; Goldstein and Johnson, 1997).

Studies which have explored women's experiences of infertility have highlighted the negative disruption of infertility on women's lives, well-being and identity, including feelings of stigma, vulnerability, worthlessness, grief, depression, isolation, guilt, loss of control, marital stress, life course disruption and their experience of infertility as a spoiled identity (Franklin, 1997; Becker 2000; Ulrich and Weatherall, 2000; Inhorn, 2003; Allan, 2006; Culley et al., 2009; Culley, 2012; Hudson and Culley, 2014).

Infertility is often experienced as a 'secret' and 'hidden' stigma (Whiteford and Gonzalaz 1995) although its hiddenness is heavily shaped by the contexts in which it is experienced (Reismann, 2000; Bharadwaj, 2003; Hudson and Culley, 2014).

Despite the World Health Organisation's definition of infertility as a disease of the reproductive system, amongst scholars, it is generally accepted that infertility is a socially constructed condition shaped by factors such as degrees of pronatalism, perceptions of infertility and patriarchy (Greil et al., 2011). Nonetheless, those who decide to use ARTs, in particular gamete donation, are reported as feeling stigmatised for using this route to reproduction on the grounds that it deviates from the norms of natural and non-commercialised reproduction (Stanworth, 1987; Franklin, 1990; Macklin, 1991; Stacy, 1992; Strathern, 1992a; Franklin, 1995; Dolgin, 1997; Becker, 2000; Harrington et al., 2008). In such cases, revealing the use of gamete donation to others inherently reveals one's own infertility. Studies have reported that recipients of donor gametes saw a lack of physical resemblance between themselves and their child as stigmatised and as a threat to the legitimacy of their family and potentially revealing of their 'spoiled identity' (Becker et al., 2005).

2.3.6 The Accomplishment of Kinship and Reproduction through the Clinic

From the 1990s onwards ARTs and have been used as an ethnographic window through which to explore kinship discourses and assumptions (McNeil et al., 1990; Stacey, 1992; Strathern, 1992a, 1992b, 1992c; Edwards, 1993; Edwards et al., 1997; Richards, 1997; Franklin and Ragoné, 1998; Carsten, 2000, 2004; Atkinson et al., 2001; Franklin and McKinnon, 2001; Konrad, 2005; Thompson, 2005; Bonaccorso, 2009; Freeman et al., 2014). The main focus of this work has been on recipients constructions of kinship although some scholars have also explored clinicians'

constructions of kinship, predominantly in the field of new genetic technologies (Finkler, 2000; Atkinson et al., 2001; Featherstone et al., 2006; Cunningham-Burley, 2008).

The main questions posed in the literature exploring the impact of ARTs on kinship and the family have been: “To what extent are the different family types produced by the use of the ARTs supportive of a particular (that is, dominant) ideology of family life?” (Haimes, 1992: 164) and ‘How do recipients constructed relatedness with their child in the absence of a bio-genetic tie?’ (Strathern, 1992b; Franklin, 1995; Ragoné, 2000; Thompson, 2005; Harrington et al., 2008).

On the one hand, scholars have reported how the use of donor gametes challenges the normative ideology of the family by separating the triad of sex, marriage and procreation (Stanworth, 1987), undermining the legitimacy of genetic parenthood (Robertson, 1991) and disrupting the “unity of procreative and conjugal function” (Franklin, 1990: 222). In the UK, the Church has historically opposed the use of gamete donation on these grounds, arguing that the use of a donor is akin to a form of adultery and that children conceived through sperm donation should be regarded as illegitimate (Pfeffer, 1993). The increasing use of sperm donation by lesbians and single women can also be seen as a direct challenge to the heterosexual, patriarchal institution of the family (Franklin, 1990; Haimes, 1992; Stacey, 1992).

On the other hand, scholars have argued that the use of egg donation reinforces the traditional ideology of the family as a heterosexual two parent family unit by seeking to reproduce a sense of genetic/biological relatedness (Haimes, 1992; Stacey, 1990; Strathern, 1992a; Pfeffer, 1993; Dolgin, 1997; Daniels, 2005; Mamo, 2007). In this regard, scholars have argued that legislation and clinical practices have developed according to the contours of the traditional family (Robertson, 1991; Haimes, 1992;

Fogg-Davis, 2001; Campbell, 2007). The reinforcement of the traditional ideology of the family is also evident in individuals' stratified access to ARTs, where access to reproduction has traditionally been granted to heterosexual, married, white middle class couples whereas those deemed 'unsuitable' to access ARTs have been denied access by virtue of their relationships, ethnicity, sexuality, behaviour or disabilities (Millns, 1995; Price, 1997; Steinberg, 1997; Roberts, 1999; Malin, 2003; Szkupinski-Quiroga, 2007).

One of the major recent themes to arise from recent studies on gamete donation has been the importance of 'resemblances', more specifically, the use of physical resemblances in constructing and displaying relatedness (Becker et al., 2005; Mamo, 2005; Hargreaves, 2006; Grace et al., 2008; Harrington et al., 2008; Culley and Hudson, 2009a; Nordqvist, 2010). These studies have found that recipients of donor gametes saw 'race' and ethnicity as a central feature of displaying resemblance and constructing relatedness with their child (Becker, 2000; Becker et al., 2005; Mamo, 2005; Thompson, 2005; Culley and Hudson, 2009a; Nordqvist, 2010; Hudson and Culley, 2014), as will be explored further below in the literature on matching.

Outside of the field of ARTs, building on the work of Morgan (1996), Finch (2007) has highlighted the importance of 'displaying' as well as 'doing' families and the strategies used by families to gain recognition as a family by others. In their research with donor-conceived families Becker et al. (2005) argued that family resemblances are used to support a hierarchy of family legitimacy, where clear resemblances are regarded as confirming belonging to a 'blood' relationship whereas unclear or lack of physical resemblances lead to questions about the authenticity of family relationships, individual belonging and to stigma (Becker et al., 2005: 1301). One of the ways in which notions of blood relatedness are expressed then are through comments and

queries about a child's physical resemblance to its parents and other family members, dialogue which Becker et al. (2005) have termed "resemblance talk".

According to Becker et al., (2005), 'resemblance talk' constructs a child's identity within the family and legitimises the child as part of the family. Thus for donor-conceived families, where there is an absence of a bio-genetic tie, scholars argue that a lack of physical resemblance between family members is regarded as a threat to recipients' display of normative family. As highlighted by Haines (1992: 168), donor-conceived families face:

"The constant potential of being exposed as something other than an ordinary family... they can give themselves away or others can make connections which suggest there is something not quite right because of a particular mix of eye colour, for example, or perhaps blood group."

Studies looking at donor conceived families' constructions of relatedness have found that parents of donor-conceived children strategically used physical and social resemblances as a resource through which to invoke relatedness and as a means of 'legitimatising' kinship ties between the non-genetic parent and their child (Hayden, 1995; Becker et al., 2005; Thompson, 2005; Hargreaves, 2006, Harrington et al., 2008; Cadoret, 2009). Thus, while the importance of the bio-genetic tie was challenged by these families through the use of a donor it was not completely displaced but mobilised in an elastic way, 'as if' it were present (Hayden, 1995).

Looking at how kinship is accomplished in fertility clinics Thompson (2005) developed the concept of 'ontological choreography' to show how far from being the outcome of random arrangements the (re)production of parents and children through ARTs is the outcome of "the dynamic coordination of the technical, scientific, kinship, gender, emotional, legal, political, and financial aspects of ART clinics [...]" things that are generally considered parts of different ontological orders (part of

nature, part of the self, part of society)” (ibid: 8). Such co-ordinations also reveal the ontological separation between things and how one type of thing is reduced into another. For example, a recipient of donor eggs is at once a patient of biomedical procedures, a consumer of biomedical procedures and a potential parent in which her fertility is reduced to her age and follicle-stimulating hormone (FSH) levels.

When choreographies ‘go wrong’, e.g. when a patient can’t afford to access treatment, or does not get pregnant, Thompson (2005) argues that this can lead to an ontological failure where the patient becomes objectified. However, Thompson (2005) also highlights that agency and objectification are not necessarily opposed and that women can strategically achieve agency through objectification. Comparing women’s experience in the clinical context of egg donation and surrogacy, Thompson (2005: 149) argues that women exercise agency through a process of “strategic naturalization” in which “patients exercise agency and claim or disown bonds of ancestry and descent, blood and genes, nation and ethnicity” to suit their individual strategies of parenthood; certain elements of kinship differentiation are foregrounded and recrafted whilst others are minimised.

2.4 Donor-Recipient Matching in Gamete Donation

The section below explores the empirical literature on matching, drawing on studies which explore the perspectives, practices and roles of clinicians and recipients and shows how gaps in this literature informed the research questions for this thesis.

There are two basic models of matching in gamete donation. One is that of ‘donor selection’, where the recipient selects their own donor, often with access to lots of information about donors; this model of matching is associated with commercialised contexts of egg donation with a relatively high supply of donors (such as the USA).

The other model is that of ‘donor allocation’, where fertility providers allocate donors to recipients and typically offer varying amounts of information to recipients about donors. Sometimes recipients can state their preferences for donor characteristics and choose to accept or decline a donor under offer. This model of matching is associated with highly regulated contexts of egg donation, with both a high (e.g. Spain) and low (e.g. UK) supply of donors. However, the fast-paced changing nature of the field of gamete donation means that in practice elements of both models can exist in some capacity and that in the UK there has been a move towards a ‘donor selection’ model and importing donor eggs from abroad.

The regulation of matching varies between countries, as will be explored further in Chapter 4. However, different models of matching can exist in the same context and so the regulation of gamete donation is not the only determinant of which model is used. For example, in the USA (not centrally regulated) and UK (highly centrally regulated) both models exist, to different degrees. In sperm donation, where there is a relatively larger supply of donors (internationally) and where the freezing of donor sperm is common practice, models of donor selection are typical and the commercialisation of donor sperm is generally accepted (Schmidt and Moore, 1998; Barney, 2005; Almeling, 2007; Mamo, 2010; Daniels and Heidt-Forsythe, 2012; Glennon, 2012).

Most of the studies on donor-recipient matching in egg donation have taken place outside of the UK in international and transnational context of egg donation. These studies have predominantly been undertaken in highly commercialised contexts of egg donation in which there is a relatively high supply of donors. This includes studies of white American recipients travelling to India (Deomampo, 2015, 2016) and to Mexico (Schurr, 2016), Israeli recipients travelling to Romania (Nahman, 2006), Danish recipients travelling to Spain (Kroløkke, 2014), Nordic recipients travelling to Finland

(Homanen, 2018), German recipients travelling to Spain and Czech Republic (Bergmann, 2011), UK recipients travelling abroad for treatment (Hudson, 2017) and “foreigners” travelling to Thailand (Whitakker and Speirer, 2010).

Researchers have generally focused on matching as part of wider studies on egg donation and sperm donation, including studies in the USA (Roberts, 1999; Becker, 2000; Fogg-Davis, 2001; Thompson, 2005; Almeling, 2007; Szkupinski-Quiroga, 2007; Martin, 2018), Israel (Kahn, 2000; Birenbaum-Carmeli, and Carmeli, 2010), Italy (Bonaccorso, 2009), Brazil (Costa, 2007), India (Bharadwaj, 2003) and Argentina (Ariza, 2015) and the UK (Price, 1997; Konrad, 2005; Klotz, 2014; Braverman and Frith, 2014; Hudson and Culley, 2014; Zadeh, 2016a)

In the UK, studies of egg donation have explored recipients’ preferences for donor characteristics or recipients’ practices of selecting donors outside of the clinical context (Ahuja et al., 1997; Hudson and Culley, 2014) and inside (Konrad, 2005; Braverman and Frith, 2014; Klotz, 2014; Zadeh et al., 2016a) and have reported recipients’ preference for and interaction with donor information (Stuart-Smith et al., 2012; Rubin et al., 2015). Theorisation of recipients’ preferences for gamete donors has received more attention in the arena of sperm donors, particularly with lesbian couples (Hayden, 1995; Jones, 2005; Mamo, 2007; Almack, 2008; Nordqvist, 2010).

Few studies have explored clinicians’ perspectives and practices of matching with any primacy in the UK context of donor allocation (Price, 1990; 1997). Some ethnographic studies have touched on this as part of their wider focus on egg donation in the UK (Konrad, 2005; Klotz, 2014) although these studies did not explore the process of matching in egg donation in-depth. More recently, Braverman and Frith (2014) and Zadeh (2016a) have reported some preliminary findings on recipient preferences for donor characteristics and donor information in the clinical context.

Matching in egg and sperm donation has been theorised according to different types of ontological orderings. Scholars have theorised matching in relation to anonymity and secrecy (Price, 1997; Pennings, 2000), mate selection (Scheib, 1994), consumption (Becker, 2000; Mamo, 2010; Nordqvist, 2010), “biomedicalisation” (Mamo, 2005), kinship and family legitimacy (Jones, 2005; Thompson, 2005; Mamo, 2007; Nordqvist, 2010) and processes of ‘othering’ (Schurr, 2016). Most of these theories of matching arose outside of the UK context of matching in egg donation. Scholars have also theorised matching as a racialising practice, in which ‘race’ is reified and reproduced (Roberts, 1999; Fogg-Davis, 2001; Fuscaldo, 2006; Szkupinski-Quiroga, 2007; Thompson, 2009; Nordqvist, 2010; Deomampo, 2015; Hudson, 2015).

These researchers have typically theorised matching within a wider framework of consumerism and commercialisation. This is because researchers have posited their studies in contexts of neo-liberalism, with low state regulation, a high supply of donors and privatised access to treatment, where recipients often pay money separately to egg donors, fertility clinics, lawyers and mediating egg donation agencies. Even in the UK, researchers of gamete donation have highlighted the importance of the wider commercial context in which matching takes place (Konrad, 2005; Nordqvist, 2010). According to Zadeh et al. (2016a) for example: “the contemporary climate of assisted reproduction is characterized by commercial practice” (Zadeh et al., 2016a: 330; Konrad, 2005; Nordqvist, 2010). However, researchers have seldom extrapolated on the nature and implications this.

Despite the large number of researchers using ethnography to study ARTs in the UK in the 1980s and 1990s (Stanworth, 1987; McNeil, 1990; Stacey, 1992; Strathern, 1992a, 1992b, 1992c; Edwards et al., 1993; Franklin, 1997; Franklin and Ragoné, 1998), the lack of attention paid specifically to matching is surprising. Despite ‘clinic-

mediated' matching being an 'institutionalised' practice in the UK (Haines, 1992), this stage in the treatment process with donor gametes has generally been neglected by wider literature on the medicalisation of reproduction. The paucity of ethnographic studies in the UK context of egg donation is especially surprising, and unfortunate given the traditional model of donor allocation in the UK.

Recognising the limits of current research in this area and building on concepts discussed earlier in this chapter, this study sought to explore the organisation of matching in UK egg donation. This overarching aim is broken down into 4 sub-questions which are outlined and contextualised in existing literature on matching in the following sub-sections.

2.4.1 Clinicians' Perceptions and Practices of Matching

According to a number of authors the main socio-psychological considerations underlying donor-recipient matching stem from issues of secrecy and anonymity (Haines, 1992; La Lannou et al., 1997; Pennings, 2000; Pennings, 2001) which have been described as the "linchpin" of medical practice using donor gametes (Price 1997). Donor-recipient matching can be seen as part of a wider "culture of concealment" in donor fertility treatment (Price, 1997: 221) and has been attributed to a biomedical model of reproduction and a desire to conceal the use of donor gametes (Price, 1997; Hudson et al, 2009).

Unlike in the USA, the distribution of donor gametes (and healthcare more generally) in the UK has been based on an ethos of 'need' rather than 'ability to pay' (Pennings, 2001, 2005), although ideological and subjective decision making may also influence regulation and clinical practice (Warnock, 1984; Malin, 2003). Studies looking at clinicians' practices of donor allocation have found that clinicians seek to match for

resemblance, regardless of whether legislation on matching exists, e.g. in Spain and Finland where matching is legislated (Bergman, 2015; Homanen, 2018) and in India, Israel and Mexico where matching is not regulated (Kahn, 2000; Deomampo, 2016; Schurr, 2016).

Researchers in the UK who have considered the role of clinicians in donor allocation have highlighted the subjective nature of clinician's decision making in this context, where clinicians are required to make social judgements that go beyond the purely medical (Millns, 1995) based on personal and ideological assumptions about who and what makes a family (Campbell, 2007). Although a few researchers have touched on the role of clinicians in matching in the UK context of egg donation (Price, 1997; Culley, 2005; Konrad, 2005; Campbell, 2007; Klotz, 2014) they have not explored the organisation of matching and the perceptions and practices of clinicians and recipients in-depth.

In her ethnographic study of 10 fertility clinics in the UK, Price (1990; 1997) found that clinicians raised concerns and uncertainties about their capacity to make decisions which went beyond the medical. Clinicians felt uncomfortable with engaging and presiding in debates which were less about risks of a technical, safety or efficacy nature and more about the perceived 'social risks' of gamete donation (Price, 1990), and were unclear about their role in 'ethnic matching' (Price, 1997). Furthermore, in the absence of clear guidance or appraisal Price (1997) found that clinicians made matches on pragmatic grounds (e.g. availability of donors and recipients).

During the time at which HFEA policy on 'ethnic and physical matching' existed (see Chapter 4) UK studies reported variability in clinicians' decision-making, whereby some clinicians refused to 'transracially' match donors and recipients, citing welfare

of the child concerns, whilst others were willing to allow it on pragmatic grounds (Millns, 1995; Birdsall and Edwards, 1996; Price, 1997; Culley, 2005; Culley et al., 2004; Thompson, 2005; Campbell, 2007). According to Millns (1995: 94), such pragmatism highlights the subjective and variable nature of clinicians' decision making: "the justification of the decision to implant a black woman with a white donor's egg on the basis of the unavailability of black donor eggs shows the fluidity between decision-making on clinical and social grounds." However, much of these commentaries and studies were based on anecdotal evidence rather than systematic exploration of matching or were based on quantitative surveys (and so were unable to explore matching in any depth).

In 1996, Birdsall and Edwards (1996) undertook a telephone survey of 46 licensed egg donation clinics in the UK and found that the majority of clinicians were not willing to offer white donors to BME recipients and that a minority of clinics would only do so after recipients underwent counselling. Furthermore, whilst some clinicians saw it as acceptable to offer a white donor to a South Asian couple this wasn't equally the case for black couples (ibid). These findings were echoed by Murray and Golombok's (2000) survey. However, the quantitative nature of these surveys prohibited in-depth exploration of the meanings that clinicians attached to their responses. What is revealed from these surveys however is that although BME women may be successful in gaining access to fertility clinics their colour may still be a factor in determining whether or not they receive treatment (Millns, 1995).

Numerous studies have reported that clinicians' refused to grant recipients' request for a donor of a different 'race' (Fogg-Davis, 2001; Culley, 2005; Konrad, 2005; Mamo, 2005; Almeling; Campbell, 2007; Costa, 2007; Szkupinski-Quiroga, 2007; Thompson, 2009; Klotz, 2014; Deomampo, 2016; Schurr, 2016), often referencing welfare of the child considerations (Millns, 1995; Culley, 2005; Thompson, 2005;

Campbell, 2007). Clinicians' refusal to meet recipients' requests also highlighted how clinicians' and recipients' view of a 'good match' might differ (Hudson, 2015). Outside of the UK context of egg donation, scholars have depicted fertility providers as businesses that geneticise and commodify donor characteristics, such as 'race', when marketing donors to recipients (Mamo, 2005; Almeling, 2007).

The social and subjective nature of clinicians' decision-making in matching has been alluded to in ethnographic studies of gamete donation in the UK. In the 1990s, Konrad (2005: 142) found that the most valued skill of the co-ordinator by staff in the clinic was their "ability to draw together visually, in the mind's eye, what future offspring would look like when all parties to the conception are blended into one entity as the mix of a visible 'match.'" Klotz (2014) also compared the management of donor information in the UK and Germany although like Konrad (2005) she did not observe or report on clinicians' matching practices in egg donation in any depth.

In contexts of donor allocation outside the UK researchers have also highlighted the powerful role of clinicians in defining desirability and acceptability in reproduction (Roberts, 1999; Szkupinski-Quiroga, 2007; Deomampo, 2016; Schurr, 2017) and that they were "hypervigilant about donor choices to keep boundaries from blurring" (Szkupinski-Quiroga, 2007). In India, Deomampo (2015; 2016) showed how clinicians labelling women as 'demanding' or 'compliant' intersected with other cleavages of (un)desirability.

Here, women who were highly educated, had light skin tone and thus were closer to Euro-American ideals of beauty, i.e. "Diva donors" were more valued by clinicians as egg donors but were seen as too uncompliant to be surrogates. On the other hand, women with darker skin tone and no education were regarded as compliant enough to be surrogates but not genetically desirable enough to be egg donors (Deomampo,

2016). More recent studies have also explored how clinicians distinguished between ‘types of whiteness’ when matching (Kroløkke, 2014; Schurr, 2016). For example, in Spain, clinicians distinguished between women with “lighter” skin tone from northern Europe (e.g. UK and Germany) and “darker” southern European women and avoided matching donors and recipients on the basis of this distinction (Homanen, 2018: 237; Bergmann, 2015).

Little is known about clinicians’ perceptions and practices of matching in the UK, e.g. about what they see as an ‘acceptable’ or ‘unacceptable’ match, their view of recipients’ preferences and to what extent they take these into account when matching. Reflecting on the UK context of matching, Hudson and Culley (2014: 246) highlight that “the role of health professionals in the process of donor-recipient matching in the context of identifiable donation is an issue worthy of further research”. The current state of the literature and knowledge on ethnic-matching has been well summed up Lorraine Culley in her evidence to a Parliamentary Science and Technology Committee over a decade ago:

“Current practice on this [inter-ethnic donation] seems to be variable. It appears to be decided by individual clinics or clinicians using the “welfare of the child” clause [...] What is the thinking behind this? On what basis is this decision made in individual clinics? Whose right is it to decide? Should minority ethnic patients who have virtually no possibility of achieving a pregnancy because of the shortage of “non-white” eggs be denied treatment? [...] In my view further research on this issue is urgently needed.” (Culley, 2005).

In view of calls for further research in this area and in response to a paucity of research exploring the role of clinicians in matching in the UK, the following research question was posed: How do clinicians allocate donors to recipients? (Chapter 6)

2.4.2 Clinicians' Classification of Donor Characteristics

According to the literature on matching, all clinics classify donors according to 'race', ethnicity and skin tone, although different categories and methods of classification are often used in different clinics (Pennings, 2000; Costa, 2009; Thompson, 2009). Nonetheless, variability in who classifies these characteristics, how such classifications are reached and interpreted can render the outcome subjective, dubious and obsolete for the purposes of 'objective medical' comparison (Fogg-Davis, 2001; Szkupinski-Quiroga, 2007; Fox, 2008; Thompson, 2009). According to Thompson:

“The central paradox of egg donation, that donor selection is organised according to psychological, social and medical qualities [...] is contradictory to the scepticism expressed about biological heritability of complex social and natural traits” (2009: 146).

The classification and use of skin tone in matching has thus been criticised for obscuring the difference between the physical expression of genes (phenotype) and the inheritance of genes (genotype) (Fogg-Davis, 2001; Szkupinski-Quiroga, 2007; Thompson, 2009). While it must be true that phenotypic variation has a genetic basis there is no consistent categorisation across characteristics (Sheldon and Parker 1992; Aspinall, 2005; Outram and Ellison, 2006; Bhopal, 2007). This has led Thompson (2009: 147) to argue that within donor selection “a consideration of skin tone in egg donation illustrates active processes of the racialisation of biology and the biologisation of race.”

There have been no studies in UK on how clinicians classify donor characteristics or how 'ethnicity' is operationalised e.g. whether 'ethnicity' is based on donors' parents' ethnicity or birthplace, that of their grand-parents, on a socio-political identity or on skin colour (Sheldon and Parker, 1992). As highlighted by Hudson (2015), there has

been a paucity of research on how clinicians operationalise ‘ethnicity’ and “racialised markers of heritability” in the context of egg donation:

“The limited existence of empirical research, which specifically examines the ways in which racialised markers of heritability are operationalised within clinical practices, is surprising [...] Studies which explore in detail the operationalisation of racial categories and related decision making of clinicians, gamete ‘brokers’ and recipients would significantly advance understanding of these processes” (Hudson, 2015: 4).

Given this evident gap in current research the following research question is posed:

How do clinicians classify donors and recipients into categories for the purposes of matching? (Chapter 5).

2.4.3 Recipients: Matching as a Kinship Practice

Studies employing quantitative surveys to explore recipients’ preferences for donor characteristics, many of which have been undertaken outside of the UK, have focused on recipients’ prioritisation of donor characteristics. Studies have found that, on the whole, women prioritised egg donors’ ‘health’, then ‘race’/ethnicity and physical characteristics (eye colour, hair colour, height and weight), followed by intelligence or personality (Le Lannou et al., 1997; Lindheim and Sauer, 1998; Lindheim et al., 2000; Broderick and Walker, 2001; Flores et al., 2014). On the whole, participants wanted to match donors’ characteristics with their own. Some studies have also reported that recipients saw donors’ social characteristics, such as their personality, education or lifestyle, were described as the most important criteria when selecting a donor (Heinemann-Kushinsky et al., 1995; Lindheim et al., 2000). However, quantitative nature of these studies meant that little attention was given to why recipients prioritised certain characteristics in donor selection, the meanings they attach to their choices or the factors shaping their choices.

Researchers using a qualitative paradigm to explore recipients' preferences for donor characteristics have often used a kinship studies framework to interpret their findings (Haimés, 1992; Konrad, 2005; Thompson, 2005; Nordqvist, 2010; Klotz, 2014). The main question posed by these researchers has been 'how do recipients construct kinship with their child in lieu of having a genetic tie with them?' which has included related sub-questions such as 'how do recipients make their donor-conceived child their 'own'?' and 'how do recipients' process the role of the donor?'. These questions have often informed researchers' contextualisation and interpretation of their findings within a wider framework of family and kinship studies.

As such, researchers have theorised recipients' preferences for a donor with similar characteristics to their own, for resemblance, as a 'kinship device', used to construct relatedness and connections with their child (Ragoné 2000; Becker et al., 2005; Konrad, 2005; Thompson, 2005; Hargreaves, 2006; Harrington et al., 2008; Nordqvist, 2010; Hudson and Culley, 2014). According to researchers, recipients seek to match donors to themselves on phenotypic grounds so that a potential child will resemble the recipient as much as possible. In this respect, the primary aim of matching for recipients and clinicians alike has been to select a donor who would be a "credible genetic substitute" for themselves (Le Lannou et al., 1997) so that a 'good match' or an 'acceptable match' is one where a child could 'pass' as the 'natural' offspring of its parent, the recipient (Becker, 2000; Konrad, 2005; Campbell, 2007; Szkupinski-Quiroga, 2007; Burr, 2009; Thompson, 2009).

In light of the increasing culture of openness and disclosure around gamete donation, some writers have argued that the "secrecy motive" that has been so intertwined with matching may make matching for resemblance less important (Scheib, 1994; Pennings, 2000: 509). However, researchers have found that resemblances are equally important to lesbian and heterosexual couples, who intend to be open about their use

of donor gametes (Hayden, 1995; Jones, 2005; Mamo, 2005; Hargreaves, 2006; Harrington et al., 2008, Nordqvist, 2010) thus “invalidating the secrecy motive” for matching (Pennings, 2000). More recently, researchers have argued that recipients match for resemblance in order to secure family legitimacy, to construct kinship relatedness with their child and to enable their child to feel a sense of belonging within the family (Hayden, 1995; Becker et al., 2005; Becker et al., 2005; Mamo, 2005; Hargreaves, 2006; Harrington et al., 2008; Cadoret, 2009; Nordqvist, 2010).

Matching was therefore used as a resource by recipients for “naturalising kinship” (Thompson, 2005; Burr, 2009) in “constructing the child as if it was theirs biologically” through the use of phenotype as one indicator of (the social recognition of) biological relatedness (Nordqvist, 2010: 1135). Looking at lesbian couples selection of sperm donors in the USA, Mamo (2005) argues that the choices and meanings underlying recipients’ donor selection practices have led to a “biomedicalization of kinship” in the context of donor ARTs where “the power of genetics is omnipresent as sperm selections are made and futures are imagined” (2007: 194). Central to Mamo’s (2005: 258) argument is that donor selection is a mechanism for constructing a form of relatedness which she calls “affinity ties”, which are mutually constituted through ‘practices of sperm selection, users themselves, and sperm bank services’.

Affinity ties are a kinship device underpinned by the imagining of shared social and cultural characteristics between recipients and their offspring, where the donor’s characteristics, such as ‘national origin, religious ancestry, cultural interests, hobbies, and social characteristics’, are mobilised to be imagined as shared with parents to be and treated “as if” they were genetically inheritable by resulting offspring (Mamo, 2007:205). This is done in order to allow couples to imagine a future child and future ‘affinities’ with it, referred to by Konrad (2005: 46) as “social connexions”. Mamo

(2005) argues that for lesbian couples 'affinity ties' are also a way of privileging social legitimacy and affirming family connections to those outside of the family:

"The social and the biological, the natural and the cultural, the genetic and the social are negotiated and merged as futures are imagined and legitimacy is maximised. That is, this merging is performed not only to share affinities but also to secure social legitimacy" (Mamo, 2005: 258).

Thus, whilst acknowledging the role of women's agency in reinforcing and subverting technological scripts of matching (according to their own needs) scholars have highlighted how this agency is exercised within wider structural and ideological constraints (Franklin, 1997; Mamo, 2007). In other words, recipients' choices were embedded within and reinforced dominant hetero-normative ideas about whom or what makes a family (Haines, 1992). As such, recipients reproduced wider ideological conceptualisations of reproduction and kinship through exerting their agency (Thompson, 2005). Thus, as highlighted by Mamo (2007: 248), although ARTs "provide the institutional and technical practices necessary to bypass social conventions of the heterosexual family [...] they do not necessarily bypass cultural and social ideals of what and who make a family".

Researcher who have focused on the experiences of lesbian couples argue that matching carries specific meaning in the context of lesbian reproduction and is used instrumentally by women to counteract discrimination in their everyday lives (i.e. homophobia) (Mamo, 2005; Nordqvist, 2010). Thus, in addition to being a strategy for 'biogenetic construction' (or 'affinity ties') these scholars argue that for lesbian couples matching "highlights the normative importance of looks and physical resemblance for the recognition and legitimization of (marginalized) family relationships" (Nordqvist, 2010: 1139-1140). However, the importance of physical resemblances for providing social legitimacy for heterosexual couples has also been

highlighted by researchers, whereby heterosexual couples face a different type of stigma in relation to heteronormative expectations of their relationship and fertility (Becker et al., 2005; Hargreaves, 2006; Harrington et al., 2008).

Reflecting a tension within the wider literature on recipients' conceptualisation of donors, Mamo (2005) and Nordqvist (2010) differ in their conclusion of how the lesbian couples in their studies processed the role of the donor when constructing kinship with their child. On the one hand, Mamo (2005) and others (Klotz, 2014) have argued that recipients re-materialise donors with full personalities when imagining their donor, which enabled them to imagine future connections with potential children. On the other hand, Nordqvist (2010), Konrad (2005) and others (Edwards and Strathern, 2000; Murray and Golombok, 2003; Braverman and Frith 2014) report that couples' construction of kinship with their child depended on their "obliteration" of their donor so that they were "out of sight out of mind" (Nordqvist, 2010).

Qualitative studies which have explored recipients' preferences and practices of selecting donors have been able to explore the meaning that recipients attached to their selection of egg donors and their prioritisation of 'race' and ethnicity. Researchers have found that 'racial' and ethnic resemblance was used by recipients as a means of facilitating the likelihood of physical resemblance (Thompson, 2001; Jones, 2005; Mamo, 2005: 258; Hargreaves, 2006; Wade, 2007; Nordqvist, 2010) through the "racialization of family resemblances" (Nordqvist, 2010: 1137). 'Race' and 'ethnicity' also invoked the notion of shared cultural and ancestral roots and genealogy through the view of 'race' as a genetically inherited property (Thompson, 2001; Jones, 2005; Mamo, 2005).

Thus recipients saw 'race'/ethnicity as a primary means of constructing affinity between themselves and their (donor-conceived) children, as well between their

children and their wider family and community (Thompson, 2001; Mamo, 2005; Hudson and Culley, 2014). In contrast to other attributes, recipients saw shared ‘race’ and ethnicity as invoking the promise of an ‘instant familial bond’ (Becker et al., 2005) More recently, scholars have also drawn attention to the importance of religion and nationality as important factors in donor selection (Inhorn, 2006; Nahman, 2006; Hudson and Culley, 2014).

However, given the shortage of donors in the UK, in particular BME donors (Price, 1997; Golombok et al., 1999; Culley et al. 2004), matching donors and recipients according to specific characteristics may be impractical (Pennings, 2000; Konrad, 2005; HFEA, 2005b). Thus, in order to avoid delays to their treatment, or to have the opportunity treatment at all, recipients may be willing to accept gametes from a donor of a different ethnicity to themselves (Fogg-Davis, 2001; Pennings, 2001; Jones, 2005; Hudson and Culley, 2014). However, the acceptance or refusal of recipients’ request to forgo ‘ethnic matching’ is typically left to ‘clinical discretion’ (Culley, 2005; Campbell, 2007).

A common theme in the literature on gamete donor selection has been the extent to which recipients seek to match a donor with their own characteristics (for resemblance) versus the extent to which recipients seek to ‘improve’ or ‘exotify’ the characteristics of their child (Hanson, 2001; Birenbaum-Carmeli and Carmeli, 2002; Mamo, 2005). Here, recipients’ preference for a donor with different characteristics to their own has typically been framed as a “consumer” choice (Birenbaum-Carmeli and Carmeli, 2002). On the whole, studies have concluded that although recipients want a donor who matches their own characteristics they are willing to compromise on this when selecting donors with characteristics that they deem to be desirable, i.e. which tended towards ideal-type characteristics of Euro-American beauty (Birenbaum-Carmeli and Carmelli, 2002; Mamo, 2005; Nahman, 2006; Bergman, 2015).

2.4.4 Recipients: Matching as a Consumer Practice

Ideas about ‘designer babies’ or ‘improving’ the characteristics of a children and families have been an ongoing concern in the literature on recipients’ selection of donors (Pennings, 2000; Hanson, 2001; Birenbaum-Carmeli and Carmeli, 2002; Mamo, 2005; Costa, 2007). According to scholars, predominantly researching in transnational or US contexts of egg donation with little regulation, matching can be seen as a ‘consumer’ or ‘commercialised’ practice (Becker, 2000; Fogg-Davis, 2001; Konrad, 2005; Nahman, 2006; Whitakker and Speier, 2010; Kroløkke, 2014; Deomampo, 2016; Schurr, 2016; Homanen, 2018).

Rather than matching donors’ characteristics with themselves, researchers have found that some recipients sought a gamete donor with different characteristics (perceived as better) to themselves. Such choices were made in relation to ‘race’, ethnicity, skin colour (Campbell, 2007; Costa, 2007, Thompson, 2009), height, temperament, musical and sports abilities (Mamo, 2005; Pennings, 2000; Hanson, 2001; Nordqvist, 2010). For example, instead of wanting to ‘match’ the skin colour of donors with themselves studies have found that some BME recipients wanted a donor with ‘fairer’ skin tone (Fogg-Davis, 2001; Campbell, 2007; Costa 2007; Hudson and Culley, 2014), which was regarded as an “attractive and/or high-status skin tone” and thus intertwined with wider histories of colonialism, imperialism and racism (Almeling, 2007; Thompson, 2009: 138).

According to Strathern (1992b: 30) donor selection practices are reflective of nature having become ‘enterprised up’ in the context of donor ARTs, where what was once seen as left to ‘nature’ (such as the random moment of conception) has now become a matter of ‘choice’. Few studies have reported instances of white couples wanting a donor with darker skin tone; where such cases have been reported, recipients’

conceptualisation of ‘racial difference’ has been framed by researchers as ‘exotic’ rather than ‘enhancing’ (Nahman, 2006; Bergman, 2015; Deomampo, 2016).

Researchers have also reported that recipients avoided selecting donors whom they perceived as having ‘undesirable’ characteristics (Mamo, 2005; Thompson, 2005). Interestingly, recipients excluded donors who might have been a phenotypical match but were seen as inappropriate for political, religious or historical reasons (Inhorn, 2006; Thompson, 2009; Whitakker and Speier, 2010; Kroløkke 2014; Hudson and Culley, 2014) or because they deviated from normative Euro-American ideals of beauty (Nahman, 2006; Schurr, 2016). Studies focusing on transnational reproduction have found that white recipients travelling abroad for egg donation distinguished between the types of white donors that they saw as acceptable or unacceptable based on skin tone and/or culture, e.g. recipients generally sought to exclude white donors from Eastern Europe but sought to include donors from Spain, Finland or Romania (Nahman, 2006; Kroløkke, 2014; Bergman, 2015; Homanen, 2018).

In the studies outlined above, researchers have had a tendency to conflate recipients’ preferences for donor characteristics, i.e. the characteristics that recipients wanted in a donor, with recipients’ practices of selecting donors, i.e. the characteristics that recipients accepted in their donor. Few studies have reported on similarities or differences between recipients’ preferences and their acceptance of donors in practice (Lindheim and Sauer, 1998). Therefore, separate exploration of recipients’ preference for donor characteristics and their practices of accepting/selecting donors would provide insight into the complex meanings and decisions that shape recipients’ negotiations and actions.

Such exploration may be especially pertinent given the shortage of egg donors in the UK, where since “a perfect match can rarely be offered” (Pennings, 2000: 512),

pragmatic factors rather than merely ideologies of family construction may shape matching practices (van den Akker, 2006: 92). Challenging the perspective of recipients as consumers who want more control in the matching process recent studies have shown that in contexts of donor allocation many recipients wanted less choice in the matching process and less information about their donor (Stuart-Smith et al., 2012; Rubin et al., 2015). Few studies have distinguished between recipients' preferences for donor characteristics (what they wanted) and their practices (what they got). The extent to which matching might be primarily described as a consumer practice in the UK context of egg donation is therefore an area worthy of further investigation.

2.4.5 Recipients' Practices of Selecting Egg Donor Selection the UK

Few studies have explored recipients' preferences, practices and experiences of matching *specifically* in relation to the UK clinical context of egg donation. Konrad (2005) reported that recipients were rarely critical about the matching process or fertility providers despite feeling they had a lack of control over the matching process; recipients were concerned about appearing "hyper-selective" and ungrateful to clinicians and worried that declining donors might jeopardise their place on the waiting list for donors. In a more recent study, Klotz (2014) reported that recipients were critical of the clinic system and did not just accept the first donor they were offered. However, a shortage of donors also meant that the recipients in both of these ethnographic studies were unable to state preferences for donor characteristics and so these researchers were unable to explore how recipients negotiated the process of selecting donors in practice (Konrad, 2005; Klotz, 2014).

A recent publication by Zadeh et al. (2016a) which reported preliminary findings from an on-going study in UK fertility clinics (using interviews) found that sometimes recipients excluded donors for reasons relating to health and fertility but otherwise accepted donors they were matched with, reflecting that they were grateful to have reached the top of the waiting list for a donor. Other studies, using structured surveys, have reported that recipients placed less importance on their donors' phenotypical characteristics after birth (Braverman et al., 2010a) and after counselling (Braverman et al., 2010b). Stuart-Smith et al. (2012) reported on the 'paradox of choice' (Rubin et al., 2015) facing recipients of donor eggs, where recipients faced a tension between wanting to know more about donors whilst wanting to retain distance with donors.

As highlighted by Zadeh et al. (2016a), in the UK context of egg donation, little is known about what preferences recipients request with clinics, their practices of accepting/declining donors that they are matched with, or indeed how the clinical context shapes recipients' preferences and practices of donor selection. Addressing these gaps in the literature, the following research questions are posed in this thesis: 'How do recipients express and negotiate their preferences in the context of the clinic?' (Chapter 7) and 'How do recipients negotiate accepting/declining donors they are matched with in practice?' (Chapter 8).

2.4.6 'Race' and Matching

The theme of 'race' pervades the literature on donor-recipient matching, as will be illustrated in the literature reviewed below. The central importance of 'race' to donor-recipient matching in gamete donation necessitates that some attention be given to this topic in its own right.

According to Szkupinski-Quiroga (2007), the practice of ‘racial matching’ reinforces a dominant hetero-normative ideology of the white family whose members resemble each other. This view echoes that of Roberts (1999), who maintained that it is not uncommon for children in BME families not to resemble their parents, especially given the variability and diversity of skin tone in these families. Scholars have argued that in matching “resemblance” is used as a neutralised code or proxy for “race” by clinicians and recipients (Ariza, 2015; Hudson, 2015; Deomampo, 2016) and that ‘race’ is reified and reproduced through matching (Fogg-Davies, 2001; Thompson, 2009; Szkupinski-Quiroga, 2009; Hudson, 2015).

According to Thompson, scholars should reframe attention from asking “(how) is race biological?” to address “how and by whom and for what purposes is race biologised and biology racialized?” (2005: 132). Scholars outside of the UK context have argued that fertility providers geneticise and commodify ‘race’ when classifying donor characteristics and later ‘selling’ them to recipients (Duster, 1990; Campbell, 2007; Costa, 2007; Schurr, 2016), particularly in contexts of donor selection where donors are advertised to recipients via catalogues (Fogg-Davis, 2001; Scheper-Hughes and Wacquant, 2002; Fuscaldò, 2006; Mamo, 2005; Almeling, 2007; Thompson, 2009).

In the last 5-10 years especially, there has been an increasing literature in matching on the “reproduction of whiteness” and its implications for stratified reproduction. The main theme to arise out of these transnational and international studies on matching has been the “reproduction of whiteness” through clinicians and recipients practices of matching (Roberts, 1999; Szkupinski-Quiroga, 2007; Cooper and Waldby, 2014; Kroløkke, 2014; Deomampo, 2015; Schurr, 2016; Homanen, 2018).

These scholars have described egg donation as a “whitening project” (Deomampo, 2015: 322), a ‘market for whiteness’ (Cooper and Waldby, 2014) and as “protecting

the purity of whiteness” (Homanen, 2018). According to these scholars, the aim of egg donation is to reproduce white babies. Here, they draw on white recipients being the main users of egg donation, primarily white donors being recruited to meet the demand by white recipients and clinicians’ expectations of racial matching and the reproduction of white fertility. Thus, it is argued that egg donation fundamentally supports “a white heteropatriarchal model of the family” (Szkupinski-Quiroga, 2007). However, the majority of recipients in the majority of these studies were white and there has been little relative exploration of BME recipients’ experiences of travelling abroad for a ‘racially matched’ donor (Hudson et al., 2011). Therefore, there is a need to explore the experiences, meanings and practices of BME recipients of donor eggs, particularly in the UK context (Culley and Hudson, 2006; Culley et al., 2009).

2.5 Research Questions

This chapter explored some of the key concepts and theories that have framed the research questions and findings of this thesis. These include: (bio)medicalisation, stratified reproduction, stratified (bio)medicalisation, racialisation and stigma. The current state of the literature on donor-recipient matching in gamete donation was reviewed with a particular focus on the UK context of egg donation and how the gaps in this literature have informed the research questions for this thesis. It was shown that to date no ethnographic studies have been undertaken in the UK context of egg donation which have focused on the stage of donor-recipient matching (often defined as ‘donor selection’). Informed by this review of the literature this research set out to explore how donor-recipient matching in egg donation is organised in two UK fertility clinics. To recap, the research questions for this thesis are:

- How do clinicians classify donors and recipients into categories?
- How do clinicians allocate donors to recipients?
- How do recipients express and negotiate their preferences in the context of the clinic?
- How do recipients negotiate accepting/declining donors they are matched with?

In the following chapter, the methodological approach and methods employed to address these research questions are outlined and discussed.

Chapter 3: Methodology

3.1 Introduction

This study was designed to be an ethnographic exploration of donor-recipient matching in egg donation in the UK clinical context. The aim of this study was to understand the organisation, meanings, practices, interactions, and context which shape the matching process.

This chapter discusses the methodology and research methods used in this study and will outline the focus of the study, the chosen theoretical orientations, the methodological approach selected and research design. This includes outlining the recruitment procedures, sampling strategies, sample characteristics, methods of data collection and analysis and reflections on my own experience of fieldwork in each research setting.

3.2 Theoretical Paradigms and Methodological Frameworks

Research paradigms refer to the ontology, epistemology and methodology which shape our understandings about what reality is (ontology), how something can be known (epistemology) and which types of procedures should be employed for finding out (methodology) (Guba, 1990). Paradigms therefore reflect a “worldview” in which there is “a basic set of beliefs that guide action” (Guba, 1990: 17). It is generally agreed, particularly in qualitative research, that one’s choice of research paradigm should be conscious, justified and explicit given its importance in shaping the design, research strategies, undertaking and analysis of research (Blaikie and Priest, 2017).

This study was informed by a constructionist/interpretivist epistemology, which holds there is no single reality or truth and that ‘multiple realities’ are socially constructed from the perceptions and interactions of individual actors (Berger and Luckmann 1991). Matching was thus regarded as the outcome of individuals’ perceptions, interpretations, meanings, actions, interactions and negotiations, and not as embodying a ‘reality’ in and of itself. Ethnography was considered most appropriate methodology to explore the organisation of clinic-mediated donor-recipient matching and the views of clinicians and recipients within the clinical context. Ethnography is used to understand peoples’ experiences and views of everyday social life and to locate this understanding within local and/or wider contexts (Hammersley and Atkinson, 2007). Ethnographic research within sociology is usually an inductive process, beginning with observations about the empirical world, the emergence of categories, and finally moving towards the development of concepts and theories (Neuman 2013). Participant observation is a defining feature of ethnography, alongside the use of multiple methods, such as interviews and documents (Hammersley and Atkinson, 2007).

Ethnography involves exploring not just what people say, but what people do, through participating in their daily activities over an extended period of time (O’Reilly, 2012). This allows the researcher to explore peoples’ accounts, actions and interactions in the context within which they occur. The aim is to gain an ‘emic’ view, i.e. the ‘insider’s perspective of reality’ (Hammersley and Atkinson, 2007). Thus research takes place ‘in the field’, allowing the researcher to document the culture, the perspectives and practices, of the people in these settings and to become an instrument of data collection (Fielding, 2001).

As such, ethnographic researchers are immersed in the context under study, taking part in the everyday practices of the research sites, building trust and rapport with participants, both participating and observing (Hammersley and Atkinson 2007: 3). Researchers are thus required to reflexively consider their own role in the construction of everyday life and on the social setting under study. Furthermore, ethnographic research involves the triangulation of various methodological approaches within the same framework (Flick, 2006; Hammersley and Atkinson, 2007), as it enables the exploration of an idea from multiple points of view and uses different research methods and investigative tools to do so (O'Reilly, 2012; Neuman, 2013)

Ethnography has a long history of use in medical sociology/anthropology (Becker et al., 1961; Bosk 1979; Strong 1979; Goffman, 1961; Atkinson, 1995) and has been a key methodology in the studies of reproductive technologies (Stanworth, 1987; Stacey, 1992; Strathern, 1992a, 1992b; Edwards et al., 1993; Ginsburg and Rapp, 1995a; Franklin, 1997; Franklin and Ragoné 1998; Carsten, 2004; Kahn, 2000; Konrad, 2005; Thompson, 2005; Featherstone et al., 2006; Nahman, 2006; Almeling, 2007; Costa, 2007; Inhorn, 2007; Bonaccorso, 2009; Klotz, 2014; Ariza, 2015). As highlighted by Thompson (2005), fertility clinics are “ideal sites” for ethnographic enquiry, as they enable researchers to show how ‘external political effects get created out of, contested by, and sustained through everyday local practices’ within self-contained clinical spaces.

This study was a multi-sited ethnographic study, undertaken across two different research sites. In line with ethnographic approaches, this study adopted multiple methods to collect data, including participant observation, semi-structured interviews with clinicians and recipients and relevant documentation/statistical information from both clinics.

3.3 Ethical Considerations

This section outlines the ethical considerations that informed the design, undertaking and writing up of this research, including the general conduct of the researcher.

According to texts on ethical research governance, key elements of good research include: valuing the diversity in society; personal and scientific integrity; honesty and openness; accountability; and ensuring that the dignity, rights, safety and well-being of participants are the primary consideration in any research study (British Sociological Association (BSA), 2002; Department of Health, 2005a). When applied to qualitative research, the implementation of these ethical principles include reflexive consideration of: (a) risk and benefits of participation to research participation, (b) participants informed and voluntary consent, and (c) confidentiality and anonymity (Beauchamp and Childress, 2001; Silverman, 2001; BSA, 2002; Hammersley and Atkinson, 2007).

Before undertaking this research, ethical approval was applied for and granted by the Ethics Committee at the Centre for Criminology and Sociology, Royal Holloway, University of London (see Appendix 1). Below I outline some of the most relevant ethical issues to this study and discuss the steps undertaken to make this an ethical research study.

3.3.1 Informed Consent

“Informed consent” is predicated on an individual’s right to choose whether to participate in a study. It is the fundamental ethical principle of ‘respect for persons’ is operationalised (Beauchamp and Childress, 2001; O’Reilly, 2012) and requires that participants be informed of the nature and purpose of the study, what participation

would involve, and the voluntary nature of this, and the potential risks and benefits of participation (BSA 2002; Hammersley and Atkinson, 2007).

Obtaining informed consent from participants is at “the heart of ethical research” (Department of Health, 2005a: 2.2.3) and requires researchers to consider their responsibility to research participants in the context of the research setting. However, obtaining informed consent from participants can be far from straightforward where ethnography is concerned (Drew, Hardman and Hosp, 2007; Murphy and Dingwall, 2007; Murchison, 2010: 61). Given that ethnography involves spending long periods of time undertaking observations of people, activities and interactions, and that in healthcare settings different actors may enter the scene at irregular and unexpected intervals, obtaining consent can be especially problematic (Murphy and Dingwall, 2007).

In this study, where private fertility clinics formed the research context, the majority of observations were focused/semi-structured observations which were pre-arranged and undertaken in relatively contained settings, such as private consulting rooms, and ‘back-stage’ spaces, such as clinicians’ private offices. Furthermore, this study was conducted overtly, so that the aims of the study, the nature of my presence in the clinics, and the voluntary and confidential nature of participation were clearly communicated to all participants.

Firstly, clinicians and clinic staff were informed about this study and my presence in the clinic before I entered the field. All patient participants were initially approached and invited to partake by a doctor or nurse, on my behalf. For each phase of the research, Information Sheets were provided for clinicians (Appendix 2) and recipients (Appendix 3). These information sheets outlined the nature of the study, what participation involved, and why they were asked to take part and were adapted for use

at each respective clinic. These sheets also emphasised that participation was voluntary and confidential, and that individuals were free to withdraw from the study at any time, without reason or repercussion. The contact details of the researcher, the complaints procedure and details of relevant support organisations were also provided.

Although obtaining written consent from participants is generally regarded as ‘best practice’, some researchers have also noted that in some contexts obtaining written consent may be more intrusive and burdensome on participants than obtaining verbal consent (Inhorn, 2004). This issue was highlighted by the clinicians in this study, who suggested that for observations of patient consultations obtaining verbal consent would be a more appropriate method of gaining consent because of: (a) the time-limited nature of patient consultations and (b) clinicians discomfort with the formal nature of my asking patients, whom they were often meeting for the first time, to sign of a consent form. Thus, for observations of patient (donor and recipient) consultations verbal consent from donors and recipients was obtained prior to observations taking place. Written consent was gained from the clinicians prior to observations taking place.

For the semi-structured interviews, written consent was obtained from all clinicians and patients prior to their interview (see Appendix 4 for clinician consent form and Appendix 5 for recipient consent form). Potential interviewees were given at least a week to consider their participation in the study. Interviews were digitally recorded where explicit and informed written consent for this recording was given. When participants did not consent to recording the interview, hand-written notes were taken. All interviewees were given the opportunity to receive a summary of the findings of this study and to discuss this further should they wish to do so (6 recipients asked for

a summary, which will be provided to them in due course). Interviewees were offered the option of being interviewed at their home, at the clinic, or in a quiet private room at Senate House, University of London Library in London.

3.3.2 Confidentiality and Anonymity

Ensuring the confidentiality and anonymity of participants is paramount to undertaking ethical research, and involves the researcher taking measures to maintain the privacy and protection of participants' identity and contribution to the study (BSA 2002). This was seen as particularly pertinent given to the sensitive nature of infertility and egg donation (Renzetti and Lee 1993; Allan, 2006).

During observations, I unexpectedly had access to identifying and confidential patient information, including patient names. Encountering such information was almost unavoidable whilst undertaking observations in the clinical setting. This included instances where clinicians discussed patients, where I could see patient information on computer screens and when I observed patient consultations. To ensure that I retained this confidentiality I made sure that I did not write down participant names or reference real names in any material. Before entering the field I signed and adhered to confidentiality agreements of non-disclosure at each clinic, in which I agreed to keep all patient identifying and commercially sensitive information confidential.

I was reflexive about my conduct throughout this study. I was mindful about the kind of information I discussed with my peers and supervisor so that I did not disclose potentially identifying information with them. The anonymity and confidentiality of participants was considered during the data collection, data cleaning and data analysis, where reflexive consideration was given to the removal of potentially

identifying information. All participants were assigned a pseudonym (code) and this pseudonym was used in the field notes, transcription and writing up of this study. Material that could identify individual participants (e.g. consent forms) was kept securely and separately from the data, accessible only by the researcher.

Protecting the anonymity was particularly challenging when describing the demographics of clinics and clinicians (because of the relatively small number of fertility providers in the region studied). To maintain anonymity, certain information was therefore removed and replaced with other characteristics which reflected the relative importance of the substituted characteristic. For example, the organisational details of clinics were amended. Personal contact details of participants were permanently destroyed after interviews had been undertaken, as were interview notes. Electronic data and documentation were stored in a password-protected folder on a password-protected computer; all data and related material were stored securely and privately in accordance with the Data Protection Act (1998). The contact details of participants who requested a summary of the research findings will be stored in a private and secure place until this has been done.

3.3.3 Managing Risk

“Risk” in social research refers to the possibility that psychological, physical, legal or social harm may occur to participants as a result of research (Eckstein, 2003: 131). The interpretative nature of qualitative research in particular could lead to participants feeling that their contributions to the study have been misrepresented or taken out of context, and so there is a risk of participants losing control over representation of their self-identity (Richards and Schwartz, 2002).

When observing and interviewing recipients, I tried to be reflexive about how this contact might influence participants and about my own responses to what I had observed or heard. I tried to be understanding and, where appropriate, sympathetic. For example, female recipients sometimes appeared visibly distressed during patient consultations and looked to me as a source of gendered support, usually during consultations with male doctors. I felt it would be unethical to ignore recipients' feelings, and my own involvement in the consultation, and so in these cases I acknowledged recipients' emotions and responded with eye contact and a sympathetic look. All of the recipients who took part in this study were provided with an Information Sheet which outlined details of support organisations. Recipients were also expressly given the opportunity to stop observations or interviews or to withdraw their data from the study (which no recipients took up).

3.4 Sampling and Recruitment

Purposive sampling was used to select the research settings for this study (Teddlie and Yu, 2007), with the selection criteria of: (a) private fertility clinics, (b) based in South East England, UK, and (c) which undertake egg donation and recruit egg donors. Fertility clinics were chosen for the important information they provide and their ability to answer the study's research questions (Patton, 2002). It is recognised that purposive sampling is a non-probability sampling method and that this may limit the extent to which findings from this study can be generalised and free from researcher bias (Brink et al., 2006). This research seeks to explore the organisation and practices of donor-recipient matching in two UK fertility clinics and how these contexts shape the views and experiences of the clinicians and recipients involved.

Whilst it is hoped that the findings of this study will contribute to an understanding of the UK context of ARTs, it is recognised that even in the UK context different clinics, clinicians, patient demographics, in different geographical locations, at different points in time, will all influence the process and outcomes of matching. Below, the sampling and recruitment procedures for fertility clinics, clinicians, recipients and focused observations will be presented, alongside the characteristics of each of these samples.

3.4.1 Recruitment of Fertility Clinics

The majority of egg donation treatments (and donor-recipient matching) in the UK are undertaken in the private sector (HFEA, 2016). Focusing on private fertility clinics also enabled the study to explore assumptions in the literature around matching as a commercialised practice by contextualising this study within a commercialised and privatised context. Clinics in the South East of England were approached because this area has the highest concentration of fertility clinics in the UK (HFEA, 2016).

Clinics which recruited egg donors ‘in-house’ and provided treatment with donor eggs ‘in-house’ were purposefully selected for inclusion in this study to enable understanding and insight into the different stages involved in donor-recipient matching, as a process, and to contextualise the role of matching within the wider clinical processes. Clinics that outsourced provision of egg donation to a partner clinic abroad were therefore excluded from this study.

Six fertility clinics which fulfilled these criteria were invited to participate in this study. After a face to face meeting, the Directors of three clinics initially agreed to participate. However, one clinic dropped out due to a change in senior management.

The remaining two clinics proceeded to participate in this study, which have been given the pseudonyms: Creative Fertility and The Fertility Centre. The two clinics recruited to participate in this study were significantly different in their size, culture, demographics and internal processes, as will be described further in the following chapter (Chapter 4). These two clinics formed the primary research settings for this study.

Below, the sampling and recruitment strategies for inviting participants to be observed and interviews will be discussed. The sample of participants recruited at each clinic was shaped by the respective size, organisation, method of recruiting participants and demographics of the patient population at each clinic.

3.4.2 Sampling and Recruitment of Clinicians

For the purposes of this study, ‘clinicians’ were defined as including doctors, nurses, directors and counsellors. The inclusion criteria for clinicians to participate in this study were for clinicians to (a) be directly or indirectly involved in matching related activities and (b) be able to provide informed consent and speak English. Administrative staff and clinicians who were not involved with the matching process were not eligible for inclusion, although they were observed and encountered during ethnographic observations in each clinic (after providing their verbal consent to this).

I was first introduced to staff members by the Director of each clinic during my second visit to the clinic. The Directors personally introduced me to the Nurse Egg Donation Co-Ordinators, who quickly became my primary gatekeepers in the field. In turn, these nurses inducted my presence in the clinic with clinicians who undertook matching activities. On each introduction, I took steps to obtain verbal consent from

clinicians and answered any questions that they had. During these introductions, clinicians were asked if they were willing to be observed, willing to be interviewed and if they were willing to approach recipients on my behalf. Clinicians were given a week to consider these aspects of participating in the study, after which, if they were willing to participate, written consent was taken. All of the clinicians who were approached agreed to take part.

Clinicians: Interviewee Characteristics

In total, interviews were undertaken with 9 clinicians. The number of clinicians interviewed at each clinic reflected the size of each clinic. At Creative Fertility 6 clinicians were interviewed. At The Fertility Centre 3 clinicians were interviewed. The characteristics of these clinicians and their role in the matching process are outlined in Table 3.1 (Creative Fertility) and Table 3.2 (The Fertility Centre) below. Although ethnicity was not a variable of interest, it is worth noting that at Creative Fertility the majority of clinicians were white and came from “Old Commonwealth” and European countries outside of the UK whilst at The Fertility Centre the clinicians directly involved in the matching process were from BME backgrounds.

Table 3.1 Creative Fertility: Clinician Characteristics

Pseudonym	Role	Ethnicity	Gender	Role in Matching
Mrs Redwood	Director	White Dutch	Female	Indirect: Managerial
Anna	Head Nurse, Egg Donation Co-ordinator	White Australian	Female	Allocation, Offering
Jemma	Nurse, Egg Donation Co-ordinator	White American	Female	Allocation, Offering
Doctor Ali	Doctor	British Indian	Female	Classification
Doctor Demetrious	Doctor	White Turkish	Male	Classification
Linda	Counsellor	White British	Female	Indirect: Point of Referral

Table 3.2 *The Fertility Centre: Clinician Characteristics*

Pseudonym	Role	Ethnicity	Gender	Role in Matching
Doctor Rana	Director	Indian	Female	Managerial, Allocation
Noreen	Head Nurse	Chinese, Malaysia	Female	Classification, Allocation, Offering
Roxanne	Embryologist	White Spanish	Female	Indirect: Point of Referral

3.4.3 Sampling and Recruitment of Patients

Recipients were invited to participate in 2 aspects of this study: observations and interviews. Donors were also invited to participate in the observational phase of this study. Details of the ethical conduct by which the recruitment of patients took place were outlined in Section 3.3 (above).

Observations

At both clinics, matching-related activities took place during patient consultations. During the ‘Initial Donor Consultation’ clinicians classified donors’ physical and social characteristics and during the ‘Initial Recipient Consultation’ clinicians classified the characteristics of recipients’ (and their partners) and recipients’ preferences for donor characteristics; these consultations were often the first time that patients were attending the clinic. During the ‘Donor Offering Consultations’ a nurse offered donors to recipients in a face-face/ telephone consultation and recipients accepted or declined the donor(s) under offer.

Whilst ‘Initial Donor Consultations’ were relatively easy to identify this was less the case with ‘Initial Recipient Consultations’, where it was sometimes difficult to single out which consultations to attend, particularly when the women themselves did not

specify or know their reason for attending. For example, on several occasions I observed consultations in which women wanted a ‘fertility check-up’, to use a known egg donor or to use their own eggs, and therefore recipients’ characteristics or preference for donors were not recorded. After consulting with doctors and receptionists at both clinics the inclusion criteria for potential recipient consultations was restricted to women in their mid-late 40s, who are the main users of egg donation (HFEA, 2014b). The process of inviting donors and recipients to have their consultations observed was similar at each clinic. All recipients and donors were approached on my behalf by a clinician from the clinic in the first instance (as explained in ‘Informed Consent’ in Section 3.3 above).

Interviews

The inclusion criteria for recipient interviewees was to (a) have accepted a donor during the period of fieldwork at each clinic and (b) be able to provide informed consent and speak English or Gujarati (researcher’s spoken languages). The stage of having accepted donors was chosen because this allowed recipients’ experiences and practices throughout the matching process (albeit retrospectively at times) to be captured, e.g. of stating their preferences, of declining donors, of deciding to accept a donor and donor information. Given that the majority of recipients in previous studies on matching have predominantly explored the views of white, middle-class women (Konrad, 2005; Mamo; 2005; Bonaccorso, 2009; Nordqvist, 2010; Klotz, 2014; Rubin et al. 2015), the intention in this study was to over-sample BME recipients.

Recipients of donor eggs were identified and approached with the help of nurses and doctors in the clinics. The recruitment of recipients for interview differed at each clinic, reflecting the individual perspectives of the nurses at each clinic (themselves influenced by other dynamics, such as the size of the clinic). At Creative Fertility,

nurses felt uncomfortable with approaching recipients for an interview whilst they were still having treatment at the clinic. Therefore, it was agreed that nurses would only contact recipients who had agreed to participate in research on their HFEA consent forms (all of whom had finished treatment at the clinic). From the 65 recipient consent forms considered, 14 recipients had agreed to being contacted, 4 recipients were deemed by nurses as being “too anxious” to approach. This led to 10 recipients being invited for an interview; two recipients did not respond and one recipient originally agreed but then stopped contact. This process resulted in a sample of 7 recipients being interviewed, including one couple (i.e. recipient and partner).

At The Fertility Centre, some recipients were approached for interview after I had observed their consultation with a clinician and some were approached by the head Nurse (who did feel comfortable approaching recipients on my behalf). All of the recipients who were invited for interviews at The Fertility Centre were therefore still in the process of having treatment and were regularly attending the clinic, often as a couple. Nine recipients were recruited through ethnographic observations (by me) and three recipients were approached by my primary gatekeeper. These processes resulted in a higher rate of interviews, with 12 recipients in total, including 12 couples.

All recipients were provided with an Information Sheet prior to having an interview and after explaining this information to recipients verbally I obtained written consent from all individuals before the interview took place (as explained in the section on ‘Informed Consent’ above). The difference in partner attendance in interviews at each clinic could have been the result of the method of recruitment used at each clinic. That is, at Creative Fertility, couples were no longer attending the clinic and so it may have been inconvenient for them to attend. At The Fertility Centre on the other hand, the

majority of recipients were still having treatment at the clinic, and so this may have made it more convenient for recipients' partners to attend the interview.

Recipients (and Partners): Interviewee Characteristics

In total, 19 recipients were interviewed. This comprised 7 recipients at Creative Fertility and 12 recipients at The Fertility Centre. The majority of recipients at both clinics were using egg donation due to age-related infertility (n=15), and the average age of the whole sample of recipients was 44 years. One recipient at each clinic was using egg donation due to pre-mature ovarian failure and were each in their mid-thirties (n=2), and one recipient at each clinic was a male same-sex couple (n=2).

Twelve recipients identified as white and seven recipients identified as BME. However, there was a noteworthy difference in how the ethnicity of recipients was distributed across each clinic. At Creative Fertility the vast majority of recipients self-defined as white (n=6) whilst at The Fertility Centre recipients came from a diverse mix of ethnic backgrounds; while 50% of interviewees self-defined as white (n=6) the other 50% came from BME backgrounds (n=6). All of the recipients were in a relationship. The majority of recipients were in a relationship with a partner from a similar ethnic (or rather racial) background to themselves (n=14) whereas 5 recipients were in a relationship with a partner of a different ethnicity to themselves. Four BME recipients had a white partner and one white British recipient had a black African partner. With the exception of one recipient (from France at Creative Fertility) all interviewees lived in the UK.

All but one of the recipients who were interviewed had accepted a donor. At The Fertility Centre one couple was interviewed at the stage of stating their preferences in the hope of interviewing them again when they had been offered a donor, but delays to this couples' treatment meant that the second interview did not take place. In one

case of a male same-sex couple at Creative Fertility (Dirk, see below), the partner of the recipient was interviewed but not the recipient himself. Below, Table 3.3 (Creative Fertility) and Table 3.4 (The Fertility Centre) outline the relevant characteristics of the recipients (and their partners) who were interviewed.

Table 3.3 Creative Fertility: Recipient Characteristics (Interviews)

Recipient Pseudonym	Recipient Age	Recipient Ethnicity	Partner Ethnicity	Stage in Treatment	Class
Ayeshah	37	British Pakistani	White British	Pregnant	Middle
Caroline	47	White British	White South African	Miscarried	Working
Helen	48	White British	White British	Pregnant	Middle
Wendy	45	White British	White British	Pregnant	Middle
Brenda & Roger	44	White British	White British	Pregnant	Middle
Camille	47	White French	White British	Pregnant	Middle
Dirk [Partner of Recipient]	42	British Chinese	White Norwegian	Awaiting Surrogate	Middle

Table 3.4 The Fertility Centre: Recipient Characteristics (Interviews)

Recipient Pseudonym	Recipient Age	Recipient Ethnicity	Ethnicity of Recipient's Partner	Stage in Treatment	Class
Aileen & Adrian	47	Black African	Black African	Accepted Donor	Working
Jan & Jonathan	41	Chinese	White British	Accepted Donor	Working
Dipti	32	British Indian	White British	Accepted Donor	Middle
Amandeep & Inderjit	49	Indian (Sikh)	Indian (Sikh)	Accepted Donor	Working
Rada & Faris	44	Iranian	Iranian	Accepted Donor	Working
Rabiaa & Nadeem	49	British Pakistani	Pakistani	Accepted Donor	Working
Uzma & Asif	42	British Pakistani	Pakistani	Accepted Donor	Working
Dan & Tina	44	White British	White British	Accepted Donor	Middle

Betty & Nick	48	White British	White British	Accepted Donor	Middle
Linda & Tim	45	White German	White British	Pregnant	Middle
Joanne & Calvin	47	White British	Black Caribbean	Accepted Donor	Working
David & Milo	41	White Italian	White South African	Awaiting Surrogate	Middle

The social class of recipients were also different. Social class is an ambiguous concept and can include a multitude of facets (Nazroo, 1998; Lareau, 2008). In this study, the socio-economic background of recipients was determined through their educational background, their occupation, the occupation of their partner and the way in which recipients talked about their ability to afford treatment. On the whole, recipients who came from middle-class backgrounds also had a higher education degree. At Creative Fertility the majority of recipients were classed as coming from middle-class background (n=6).

At The Fertility Centre on the other hand, recipients came from a mixture of socio-economic backgrounds. The majority of recipients came from working-class backgrounds (n=7), including 5 recipients from a BME background. On the other hand, 5 recipients came from a middle-class background, including 1 recipient from a BME background.

3.4.4 Sample of Observations

Observations were undertaken of a variety of matching related activities, including: focused observations of: (a) ‘Matches’ made by clinicians (donor allocation), where clinicians made decisions about which donors and recipients to match (backstage), (b) ‘Initial Donor Consultations’, in which clinicians classified donors’ physical and

social characteristics (frontstage), (c) ‘Initial Recipient Consultations’, in which clinicians classified recipients’ (and recipients’ partners) characteristics and recipients’ preferences for donor characteristics (frontstage), and (d) ‘Donor Offering Consultations’, in which a nurse offered donors to recipients in a face-face/ telephone consultation and recipients accepted or declined the donor(s) under offer (frontstage). Few instances of ‘Donor Offering’ were observed at Creative Fertility because this process was usually undertaken virtually, via e-mail. These focused observations are summarised in the table below.

Table 3.5 Sample of Focused Observations at Each Clinic

Summary of Observations	Creative Fertility	The Fertility Centre
Total No. Days Attended	80 (over 10 months)	120 (over 14 months)
Matches by Clinicians	152	35
Initial Recipient Consultations	14	6
Initial Donor Consultations	13	5
Donor Offering Consultations	2	14

At Creative Fertility, I observed 52 matches being made; this comprised the majority of matches made at the clinic over the period of observations at the clinic. I observed 13 ‘Initial Donor Consultations’ and 14 ‘Initial Recipient Consultations’. Two telephone ‘Donor Offering’ consultations were observed. The majority of donors and recipients observed being matched and in consultation were labelled as white British/white other by the clinic (90%).

At The Fertility Centre, the smaller size of the clinic meant that fewer focused observations of matches and ‘Initial Consultations’ for donors and recipients took

place. Over a period of 13 months, I observed 35 matches being made. Not all of the matches made at the clinic were observed; this is because the small size of the clinic often meant matching was done informally. However, I was able to collate information about the overall matches made, as will be explained in more detail below. I observed 5 'Initial Donor Consultations' and 6 'Initial Recipient Consultations'. I also observed 15 'Donor Offering' consultations, 13 of which were face-face and 2 over the telephone. The ethnicity of donors and recipients observed at The Fertility Centre was more mixed than at Creative Fertility, but the majority of recipients observed were labelled as BME by the clinic.

3.5 Data Collection

Fieldwork was undertaken over a period of 23 months, between January 2013 and November 2014. The first 12 months of fieldwork were spent at Creative Fertility. During this year, I spent 10 months observing matching related activities. Focused observations of 'back-stage' matching activities took place over the entire ten-month period and included observing meetings between doctors and nurses in which decisions were made about which donors to offer (or not offer) to which recipients. Observations of 'front-stage' matching activities, i.e. patient consultations, took place between months 6 and 9 of observations. Around 80 days were spent in the field during the period of observations at Creative Fertility, with each visit at the clinic lasting between 3-6 hours. Semi-structured interviews with clinicians and recipients were undertaken between months 8 and 12. Towards the end of my time at Creative Fertility, I began fieldwork at The Fertility Centre.

Fieldwork at The Fertility Centre was undertaken over a 14-month period. Eleven months were spent observing 'back-stage' matching activities, i.e. the organisation

and practice of matching; the practice of matching was observed irregularly during this period (as will be explained below). ‘Front-stage’ donor and recipient consultations were observed between months 5 and 14 of fieldwork. Around 120 days were spent undertaking observations at The Fertility Centre, with each visit lasting between 2-8 hours. Semi-structured interviews with clinicians and recipients took place between months 10 and 14 months. Fieldwork took longer at the Fertility Centre because the clinic undertook a smaller number of matches, over irregular periods of time in a more informal way. Table 3.6, below, summarises collection of data over the period of fieldwork at each clinic.

Table 3.6 Fieldwork Timeline at Each Clinic

Fieldwork Activity	2013												2014												
	Month	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Creative Fertility																									
Obs. Donor Allocation	■	■	■	■	■	■	■	■	■	■															
Obs. Patient Consultations				■	■	■	■	■	■																
Obs. General						■	■	■	■	■															
Clinician Interviews								■	■	■	■														
Recipient Interviews									■	■	■	■	■												
The Fertility Centre																									
Obs. Donor Allocation											■		■		■	■	■		■	■	■	■			
Obs. Patient Consultations															■	■	■	■		■	■	■	■	■	■
Obs. General											■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Clinician Interviews																							■		
Recipient Interviews																				■	■	■	■	■	■

The remainder of this section will outline how the methods chosen for data collection were applied to the undertaking fieldwork in this study.

3.5.1 Participant Observation

At both clinics, I undertook participant observation to explore matching related activities. Participant observation involves the researcher taking part, to various degrees, in the “daily activities, rituals, interactions and events of a group of people as

one of the means of learning about the explicit and tactic aspects of their life routines and culture” (DeWalt and DeWalt, 2002: 1). This entails viewing phenomena from the perspective of those being studied in their own settings (Bryman, 1988; Hammersley and Atkinson, 2007; Silverman, 2001) by looking, listening, watching and asking as part of the observational process (Lofland et al., 2006).

The method of ‘participant observation’ was used to explore the organisation of matching within the clinical context in which it takes place, thus enabling insight into the contextual factors which shape the different stages of the matching process (Denscombe, 2007; Hammersley and Atkinson, 2007). As a participant observer, the researcher participates (to varying degrees), observes and records events as they occur (Lofland et al, 2006; Hammersley and Atkinson, 2007). In this study, I adopted the role of the ‘Moderate Participant’ (Spradley, 1980) and ‘Observer as Participant’ (Gould, 1958), where one is identifiable as a researcher, occasionally interacts with participants, but generally ‘shadows’ a person rather than actively participating in the research setting.

During observations, I focused on and documented conversations, comments, actions, interactions and negotiations between clinicians, donors, recipients, recipients’ partners and myself. I tried to note details about the structure of each observation, such as where it took place, the duration, the physical location, who was present and the general atmosphere. This was to enable me to contextualise my analysis and interpretation of the data at a later stage. I primarily undertook what can be classed as *general/unstructured* observations of the egg donation process and organisation of the clinics and *focused* observations of matching activities.

Early *general* observations at each clinic included general and broad observations about the physical and socio-cultural organisation of the clinics and clinicians roles

and routines. Later *general* observations included observation of egg-donation related activities, including internal clinic ethics committees, biomedical procedures in the laboratory, general patient consultations and work-shadowing nurses. ‘Hanging out’ in communal areas of the clinics, such as the staff kitchen or staff room also proved valuable as this enabled insight into the organisation and culture of the clinic, facilitated relationship building with staff and contributed to legitimising my presence in the clinic.

Focused observations of ‘back-stage’ matching activities were centred around the practice of matching, but included observation of other matching activities, such as: the monitoring and updating of patients records, the un-matching of donors and recipients and matched donors and recipients going through treatment cycles. When observing matching sessions, I paid particular attention to facets such as: the structure, process and tools employed; clinicians’ interpretation and negotiation of patient characteristics; and clinicians’ reasoning for matching, or not matching, particular donors and recipients. A clear view of clinicians’ matching tools during observations allowed me to additionally document the characteristics/information about donors and recipients that clinicians drew on when matching.

Over time, I recorded information about the matches made at each clinic for a large number of cases. At Creative Fertility I documented information about 152 matches and at The Fertility Centre I documented/collated information about 65 matches. However, the collection of this data differed between each clinic.

At Creative Fertility for each match that I observed I systematically recorded: (a) the recorded ethnicity and physical characteristics of matched donors and recipients, (b) where relevant, their social characteristics and additional recorded information, (c) clinicians’ reasoning for making the match and (d) whether the matches had been

accepted or declined by recipients and if a reason had been given by recipients. During fieldwork, I collated and input this information onto an excel spreadsheet. Near the end of fieldwork, I returned to the clinic to check the accuracy of the information that I recorded against the clinic's own records (which I was given supervised access to) and to collect information that I had missed.

At The Fertility Centre, I also recorded the physical characteristics of matched donors and recipients, although it was more difficult to systematically record these. This is because the clinic did not always record the characteristics of recipients separately from recipients' preferences and because I did not observe all of the matches in the clinic being made (unlike at Creative Fertility). However, my role as 'data-inputter' at the clinic (explained further below) meant that I could record the ethnicity, height and weight of all the donors and recipients who had been matched during the period of observations. This enabled me insight into information about matches even I did not observe them directly.

As fieldwork progressed observations were expanded to include front-stage' matching activities, including 'Initial Donor Consultations', 'Initial Recipient Consultations' and 'Donor Offering Consultations'. During these observations, particular attention was paid to the interactions between clinicians, patients and technology and the ways in which donor and recipient characteristics were operationalised and mediated.

Field Notes

The data gathered from observations took the form of field notes, which form the fundamental basis of ethnographic work (Spradley, 1980). Field notes enable researchers to capture details of the setting and the context of events, actions and meanings; they can serve as aide memoires; and can be a tool for processing and clarifying fieldwork experiences (Franklin and Roberts, 2006).

The taking of field notes was a process, which involved making 'condensed' notes during observations with a note-pad and pen, in public view, writing up 'extended' notes as soon as possible on a computer the same evening, and keeping a reflexive diary (Spradley, 1980). 'Condensed' field notes included short-hand notes, quotations, comments, phrases, descriptions of events, and key words or symbols that could trigger memories about events (Lofland et al, 2006; Pope, 2005). Condensed field notes were between 6-15 pages, and were written up in fuller form later in the day with further details and reflections. It usually took between 4-9 hours to write up extended notes for a standard day of observations at the clinic. In my reflections, I noted my own thoughts, feelings, responses to and interactions with others.

At the beginning of fieldwork in each clinic some clinicians appeared slightly disconcerted at my writing of notes. These clinicians peered in to see what I was writing or asked me what I was writing about. I tried to be as open as possible with participants about what I was writing, and the purpose of making notes, and often found myself positioning my note-pad so that it was relatively visible to those I was observing. Over time, and the development of rapport and trust, clinicians appeared to normalise my note taking as part of my presence in the clinic and did not raise any further questions or comments.

As I became more familiar with the research settings and more apt at field-notetaking, my field notes became more systematic. I began to document conversations, comments, interactions, behaviours, practices and aspects of the clinics culture in more detail. I had begun writing verbatim what I had heard, even if I did not understand the jargon, with single words triggering a rich reconstruction of observed events (Fielding, 2001). I used a coding system to distinguish between individual donors and recipients so that I could track which donors had been matched with which

recipients over the period of observations (as the majority of donors and recipients were matched more than once).

3.5.2 Interviews

Semi-structured in-depth interviews were undertaken with clinicians and recipients. As highlighted by Silverman (2001: 54), although observational work can tell us about how people respond in particular settings, it is unable to explain how people constitute that setting or the meaning they attached to their actions. Thus, whilst observations of donor-recipient matching enabled insight into participants' practices, interviews with these participants allowed insight into the subjective assumptions, motivations, values, emotions, experiences, meanings and beliefs which informed and shaped their practices (Denscombe, 2007: 174). Therefore interviews were used to explore complex and subtle phenomena that had been observed, rather simply for the straightforward collection of factual information (ibid). A topic guide was used to undertake interviews. The topic guide was informed by issues that had been identified in the literature review and from prior ethnographic observations at each clinic.

The topic guide for clinicians (Appendix 6) explored: clinicians professional background; how clinicians operationalised donor/recipient characteristics; clinicians' perceptions of the purpose of matching, of recipient preferences, and of the role of the welfare of the child in matching; clinicians' conceptualisation of ethnicity and 'ethnic matching', and clinicians perceptions of a 'good match' and an 'unacceptable' match.

The topic guide for recipients (Appendix 7) explored recipients': trajectory towards egg donation; experience of the matching process; preferences for donor characteristics; and decision to accept or decline donors. Where recipients' partners attended interviews they were also asked about their views of the matching process.

Interviews with clinicians were undertaken in a private room in their respective clinics, at their request. The location of recipient interviews, at their request, appeared to be shaped by recipients' stage in the treatment process; on the whole, recipients who had finished their treatment chose to be interviewed outside of the clinic (Creative Fertility) whilst recipients who were still attending the clinic for treatment chose to be interviewed inside of the clinic (The Fertility Centre). The location of recipient interviews for participants from each clinic is outlined in Table 3.7, below:

Table: 3.7 Locations of Recipient Interviews

Clinic	Inside Clinic	Home/Outside Clinic	Telephone
Creative Fertility	2	2	3
The Fertility Centre	9	2	1

The majority of interviews lasted between 60-120 minutes and were digitally recorded, including all clinician interviews. Digitally recorded interviews were transcribed verbatim by me. Two recipient interviews were not recorded because a) of a methodological oversight on my part, not realising that I could have recorded my first telephone interview and b) the recipient requested that I did not record the interview. In both of these cases I took hand-written notes. By this time I had become accustomed to writing shorthand notes, which made this process easier.

The undertaking of individual and joint (couple) interviews had an influence on the dynamics of the interviews. On the one hand, interviews with recipients alone enabled in-depth insight into their own unmediated perceptions and experiences of their infertility and donor selection. On the other hand, interviews with couples enabled insight into couples' negotiation of recipients' infertility and encouraged spontaneous

discussion about matching, whilst also providing an opportunity for couples to corroborate or challenge one another's stories (Valentine, 1999).

3.5.3 Documentation

A range of documentation was collected during this study, both inside and outside of the clinic. Collected documentation within the clinics included paper and electronic items such as clinic price-lists, websites, published leaflets, standard e-mails, anonymised donor 'pen-portraits' (i.e. messages from donors to persons born of their donation which recipients were given access to) and standard template forms to record donor/recipient characteristics, recipient preferences and to offer donors to recipients. These latter forms contained the characteristics (and categories) used by clinicians for allocating donors to recipients and to offer donors to recipients. I also used the clinics' databases/patient files to crosscheck and collate information about the characteristics of matched donors and recipients. In this respect, the secondary data collected at each clinic were regarded as "static" or "immutable things" but as data in their own right and as a "key component of dynamic networks" (Prior, 2008).

I also reviewed government legislation, i.e. the HFE Acts 1990 and 2008, and policy/guidance from the HFEA and Department of Health in relation to egg donation, with a specific focus on the welfare of the child and donor-recipient matching and the implications for the reproduction, clinician autonomy and dominance and recipient agency (explored in Chapter 4).

3.6 Reflections on the Experience of Fieldwork

3.6.1 Reflexivity

The ‘reflexive turn’ in ethnography requires researchers to be self-critical and self-reflexive, to think about their own impact on the field and the various conditions under which research was done (O’Reilly, 2012). Reflexive ethnographers think carefully about who has the power to say and do what to whom, about what they read and write, are honest about the influences on their work, and take into account the context of research and wider structures of power and control (O’Reilly, 2012). According to Hammersley and Atkinson (2007: 15), “the concept of reflexivity acknowledges that the orientations of social researchers will be shaped by their socio-historical locations”.

Following a feminist informed ethnographic approach, I sought to be transparent in my interactions, reflexively sensitive to values of reciprocity and emotional connection in my interaction with participants, particularly recipients (Stacey, 1988; Harrison et al., 2001; Blakely, 2007).

3.6.2 Positionality

I was aware of managing my ‘presentation of self’ or “impression” at each clinic (Hammersley and Atkinson, 2007: 66). This included being aware of and adjusting my behaviour, language, actions, dress and general demeanour whilst in the field. I tried to be courteous, respectful and friendly at all times. Staff at both clinics often referred to me as “smiley” and friendly, which correlated with my own reflections some evenings that my cheeks still hurt from smiling so much all day. I think this smiley disposition was in part a response to the suspicion that I had initially felt from

clinicians, who were only used to being observed by new members of staff and external authorities, and could not understand why I was studying the ‘mundane’ process of matching.

Like the clinicians I observed, I did not generally wear any name badges or lab coats (except when in the laboratory), and I dressed smart-casual when attending the clinic as the staff in the clinic did. This was done to help me fit into the context I was in. Instead, my presence as a researcher was demarcated by my physical location during observations (e.g. sitting on a smaller chair or behind clinicians), the presence of my note-pad, and introductions in the field.

I was aware of the impact of my own ethnicity (Indian) and gender (female) on particular aspects of fieldwork. On the whole, I think my being a female in a predominantly female setting helped my acceptance in the clinic’s culture, especially where the majority of patients were female. When interviewing BME recipients it became evident that many had agreed to be interviewed, in part, because of my own ethnicity and gender, which they felt would allow me to understand their own views and experiences of infertility in relation to their central identity of ethnicity. Many of these women were particularly concerned about being misrepresented in research and their anonymity being compromised. I engaged in conversations with BME women around shared cultural values, identity and experiences of racism. However, I also emphasised that my primary role was to undertake research, and that I would seek to represent their views as honestly and insightfully as possible (as I hoped to do with all participants). When interpreting recipients’ views and experiences I tried to locate them within wider structures of power.

At The Fertility Centre, where the Medical Director/founder of the clinic and I shared a similar ethnic/religious background (Indian, Hindu), I also felt that my ethnicity

facilitated trust between the clinic and myself. This was also the case with Doctor Ali, at Creative Fertility. Like BME recipients, BME clinicians often talked to me ‘as an Indian woman’, and drew on shared experiences and world-views based on our shared ethnic backgrounds. For example, when discussing why some South Asian women wanted a donor with lighter skin tone, the Director drew on a range of cultural references informed by BME perspectives, including Bollywood, skin-lightening products, and the repercussions of colonialism and racism. I felt this ‘ethnic connection’ not only shaped the type of relationship I had with BME clinicians but also facilitated my unsupervised access to the clinic’s patient data; the trust to access this data was also enabled by my extensive integration into the clinic’s culture and my role in inputting patient data onto the clinic’s new computer system (see below). To address this ethical issue I had on-going discussions with my supervisor whilst in the field and I regularly reminded the Director and other clinic staff about the purpose of my presence in the clinic and how I intended to use the data I had access to.

3.6.3 Role in the clinics

Those experienced in undertaking clinical ethnographies in “elite” field sites highlight that the clinic is a busy place where “time is always at a premium” and a space which can be “an intimidating and confusing” for participant observers (Franklin and Roberts, 2006: 84). In this respect, I often felt aware of not having a legitimate defined role and not wanting to be obstructive, in a setting in which everyone was busy performing tasks. Initially I felt tense and awkward about my role in ‘observing’ clinicians, who were only used to being externally observed by regulators and new members of staff, and tried hard to position my presence as akin to the latter. However, as time progressed, I found myself more familiar with and engaging in the

etiquettes of the clinics and felt that my presence had been accepted by participants, which helped to legitimise and define my role as a researcher (for both participants and myself).

At Creative Fertility, I was much more of an observer than participant. The formal structure and organisation of clinic meant that there were clearly demarcated roles for staff, and so it was difficult to ‘participate’ and immerse myself in the clinic. However, attending the clinic on a regular basis to undertake general observations was more difficult, unless I had a pre-arranged reason to be there (i.e. observations of specific events and interviews). At The Fertility Centre, I was more of a participant (and observer), as I became more integrated in the clinic’s culture. However, this did not always translate into observations of matching related activities. Furthermore, at the beginning of fieldwork, my attendance at the clinic was patchy, infrequent and dependent on my gatekeeper. At The Fertility Centre, donor allocation was often undertaken informally, by clinicians in isolation or during informal meetings, making it difficult to pre-arrange observation of these sessions. Trying to observe donor allocation in the clinic was difficult, time-consuming, and often an unsuccessful process.

It wasn’t uncommon for my gatekeeper to contact me the night before arranged matching sessions to cancel my going in, or for the sessions to be cancelled on the day itself, because the clinic was “too busy” to have these sessions. For several weeks at a time my gatekeeper didn’t respond to my e-mails or phone calls and I was unable to attend the clinic. Other times, my gatekeeper would telephone me to inform me that she was “in the “mood to do some matching”, giving me less than an hour’s notice to reach the clinic. In all, my gatekeeper cancelled my going into the clinic or my observations of donor allocation for 4-5 months of fieldwork. When I told the Clinic’s

Director that I was not observing as many matches as I had hoped, she began scheduling matching sessions into the clinic's diary. However, these were frequently cancelled. Although I arranged to work-shadow the nurse undertaking donor allocation at The Fertility Centre, this did not result in significantly more observations of this practice, as the nurse continued to allocate donors to recipients outside of observations.

For the last 3 months of fieldwork, I decided to ask the nurse about the matches that she had made in retrospect, at the end of every week (as advised by my supervisor). After spending over a year in the field at The Fertility Centre I felt like I had 'failed' in finding out how donor allocation was undertaken and that despite my best efforts at systematic observation 'it was all happening elsewhere' (Hammersley and Atkinson, 2007). However, near the end of fieldwork I realised The Fertility Centre had its own model of matching, and it was this informal model of matching' that I had documented over a long period of note taking. Furthermore, I realised that to a large extent 'matching sessions' at The Fertility Centre appeared to have taken place for the purposes of this study. When I stopped asking to observe these sessions no subsequent matching sessions were scheduled in the clinics' diary (which I had access to).

Halfway through fieldwork, the director of clinic asked me to undertake a 'data-inputting' role, as the clinic had installed a new database during fieldwork and needed to transfer patient information from the existing patient files onto the new system. I agreed to input information about donors and recipients who had been matched at the clinic, and it was agreed that I could anonymise and use the information I inputted for my own research. My role as 'data-inputter' legitimised and normalised my presence in the clinic and allowed me to undertake general observations.

My integration into The Fertility Centre, at different levels over time, was also evident in the activities that I undertook at the clinic. I was commonly asked to buy milk, make coffees, to escort patients between appointments, to retrieve patient files and later to answer ringing telephones and to update patients with non-clinical information. I was told I no longer needed to sign the 'visitor book' and was invited to the staff Christmas party. Having this defined role meant that I could access the clinic more frequently, independently and easily. Whilst my access to observing clinicians' practices of matching still depended on my gatekeeper (Noreen) having a regular presence in the clinic meant that Noreen often approached me spontaneously to observe her undertaking matching activities.

3.6.4 Delays, rapport building and exiting the field

Originally, I had intended to spend 6 months, not 10-12 months, undertaking fieldwork in each clinic. I intended to begin observations of patient consultations ('front-stage) and identifying recipients for interview 2 months into fieldwork at each clinic. However, this process took longer than expected for several reasons. Although permission for this fieldwork was granted by the clinic's Directors, in practice, ethical access to patients, in particular access to recipients, was a process of continual negotiation.

On the whole, clinicians were fine with my observing their own activities in the 'back-end' of the clinic. However, they were less comfortable with me observing patient consultations, recipient consultations in particular, and interviewing recipients. The nurses and doctors indicated that they were pessimistic about whether recipients would consent to allowing me to observe their consultation, let alone consent to being interviewed. This was frustrating given that they had initially granted this access.

Clinicians were concerned that recipients might see my research as a potential risk to their anonymity and confidentiality, something which the clinic otherwise went to lengths to protect.

Within the privatised setting of clinic, I also appreciated that for both clinicians and recipients, consultations were simultaneously a time limited, commercial and medical activity. However, over the next few months I gently familiarised clinicians with the importance of my research and of understanding recipients' perspectives. Around 4-5 months into fieldwork I asked clinicians if I could observe patient consultations again, and this time my request was approved. By then I was described as "part of the furniture" by staff at both clinics and had developed relationships and trust with staff. In turn, clinicians also became more familiar and interested in my research, and were therefore keen to help me to meet the aims of my study, including having contact with recipients. In hindsight, the longer time spent observing 'back-stage' clinic activities was a necessary mechanism of building trust and rapport with clinicians and of being accepted in the clinical context (O'Reilly, 2012), which I think outweighed clinicians' previous concerns about my contact with recipients.

The decision to stop fieldwork at both clinics was determined by practical considerations and external time constraints (i.e. analysing the data writing-up within the PhD time frame). In addition, I had collected more than sufficient data for the purposes of the study. I informed staff members and the clinics Directors about my intention to leave the field 1 month prior to leaving, again nearer the time and said my goodbyes on my last days. The process of 'leaving the field' in both clinics was difficult. Having spent longer than planned at each clinic as a necessary part of fieldwork, it was difficult to know when to stop. In hindsight, I collected too much data at each clinic and spent too long in the field at each clinic. I should have

considered ending my data collection sooner. However, this immersion over a long period of time did enable me to collect a large number of cases and to document practices of matching and patterns within these.

I found that my immersion into the topic of egg donation continued even when I left the field. Outside of the clinics, I could not help but hear and see advertisements for egg donation on the tube, the radio, national newspapers and on my social media pages. I adopted the language used by clinicians in the clinic and took for granted the specialist nature of what I had learned (which I only realised through conversations with my supervisor, friends and family).

3.7 Data Analysis

This research was a qualitative ethnographic study seeking to explore the organisation of matching in egg donation in two UK fertility clinics. Qualitative research generally involves an inductive approach to data analysis in which the process of analysis is ‘driven’ by the data rather than a pre-existing hypothesis. In ethnographic research the process of data analysis is an inherently iterative one and shaped by decisions made at all stages in the research process (Hammersley and Atkinson, 2007).

The process of analysis (along with other stages in the research process) was informed by the emergent research questions, by existing literature, by emergent findings in the data and by key ‘sensitising concepts’ and theoretical frameworks (Patton, 2015) which were explicitly chosen to explore the topic under study. Thus the analysis in this thesis reflects the ‘more explicitly analyst-driven’ approach as identified by Braun and Clarke (2006), rather than a purely ‘inductive’ or ‘deductive’ approach. The sources of data which were analysed comprised: interview transcripts,

observational field notes and personal reflections from the period of data collection at two field sites.

3.7.1 Method of Data Analysis

The method of thematic analysis was used to analyse the data collected in this study. This involves the researcher searching across datasets to find repeated patterns of meaning. There is some debate about the nature and implications of ‘thematic analysis’. Some argue that it is an ‘unsophisticated’ method which merely describes patterns in data or is merely part of a process within larger analytic traditions, such as grounded theory (as highlighted by Braun and Clarke, 2006; Braun et al., 2015). Others however, emphasise the value of thematic analysis and argue that it is a method of analysis in its own right (Boyatzis, 1998; Joffe and Yardley, 2004; Braun and Clarke, 2006).

Unlike other data analysis methods, which are theoretically committed *methodologies*, thematic analysis is typically described as a “flexible” *method* (Boyatzis, 1998; Joffe and Yardley, 2004). Indeed, Braun et al. (2015: 96) refer to “flexibility” as being the “hallmark” of their approach to thematic analysis. As a method, thematic analysis can be used with quantitative, qualitative, small and large datasets, it can be used inductively or deductively and it does not tie researchers to pre-existing theoretical commitments (Guest et al., 2011; Braun et al., 2015), although it is essential that researchers are explicit and transparent about their epistemological assumptions (Braun and Clarke, 2006). Thematic analysis has also been praised for being a useful ‘contextualist’ method (Braun and Clarke, 2006: 9) which enables insight into the meaning that individuals attach to their experiences and for these to be related back to the wider social context shaping such meanings (Golafshani, 2003; Braun et al. 2015).

Braun and Clarke (2006) outline 6 key stages in this process of thematic analysis, which are often drawn upon by scholars using this method. These comprise: (1) Become familiar with the data, (2) Generate initial codes, (3) Search for themes, (4) Review themes, (5) Define themes and refine and (6) Write-up. As acknowledged by Braun et al., (2015), despite the analytical distinction between these phases in reality the relationship between them is better described as ‘fluid’ and ‘recursive’ rather than linear. This is true of the application of this process to the data in this study.

In order to organise and manage the large amount of data collected I used NVivo (qualitative data management software) to organise and code data. However, I undertook more in-depth analysis by hand. Familiarisation with the data began whilst I was still in the field, where I began to organise and review collected data and undertook some preliminary analysis. This included noting down emergent themes, points of uncertainty and information that I felt was missing, which enabled me to clarify issues and explore particular themes in-depth with participants and check the accuracy of my own collated information about matches against the clinics’ own recorded information (where this information was recorded in different places). I also became more familiar with the data as I wrote up extended field notes and transcribed interviews. After leaving the field I read the data I had collected several times to familiarise myself with its nature, contents and feel (e.g. allowing myself to be immersed in thick description), noting down my reflections about recurrent, differentiating, emergent and interesting themes.

I made the decision to analyse and write-up the perceptions and practices of clinicians and recipients separately and discuss similarities and differences between these two groups in the conclusion chapter (other decisions made throughout the analytical process will be outlined further below). Data were sorted according to ‘codes’ to begin organising it in a meaningful way (Braun and Clarke, 2006; Lofland et al.,

2006). A “code” refers to “a succinct label (a word or short phrase) that captures a key analytical idea in the data and conveys this to the researcher” (Braun et al., 2015: 100). To begin with, ‘open coding’ was used so that codes ‘emerged’ from the data. These codes were developed and modified throughout the analytical process. The analysis of ‘negative’ cases which departed from dominant accounts were especially helpful in providing contrasting interpretations of the data and illuminating and refining understanding of dominant cases (Lofland et al., 2006).

I undertook ‘semantic coding’, where descriptive information from or about participants was coded, and ‘latent coding’, which was more interpretative and focused on the “*underlying* ideas, assumptions and conceptualisations –and ideologies – that are theorised as shaping or informing the semantic content of the data” (Braun and Clarke, 2006: 13). This allowed me to capture descriptive information- such as the categories used by the clinics and more interpretative data – such as the meanings that clinicians’ and recipients’ attached to these categories. Some codes were developed from the language used by participants themselves whilst others were ‘observer-identified’ codes which reflected the meaning of the data and were sometimes borrowed or adapted from existing literature (Lofland et al., 2006; Hammersley and Atkinson, 2007). I coded paragraphs, rather than merely sentences of interest, within individual data sources to enable contextualisation of the data encompassed under codes. Thus, single data excerpts (e.g. a paragraph) and single data sources (e.g. an interview transcript) were coded re-coded and reviewed multiple times as new relationships in the data were identified.

The process of deciding which individual codes might combine to form an overarching theme took place throughout the process of analysis. The large amount of codes generated during coding meant that the process of reviewing and re-organising codes and themes could not wait until the end of the coding process (as ideally

prescribed by Braun and Clarke (2006)). As I generated a longer list of codes and built up the data excerpts under individual codes some codes and themes were re-conceptualised and re-named, some were merged and some were deleted. I reviewed all of the themes, sub-themes, codes and data within them and progressively re-organised these so that there was ‘internal homogeneity’, i.e. coherence between themes, and ‘external heterogeneity’, i.e. clear distinctions between themes (Braun and Clarke, 2006) (See Appendix 8 for an example of the recipient coding frame). This analytical work took place manually. The themes and my interpretation of them were checked across the dataset as was the relationship between individual themes and the overall thesis. I paid particular attention to similarities and differences within and across themes, exploring how different people and different levels of analysis addressed the same theme. The use of different methods and sources of data collection were especially helpful in enabling me to contrast and triangulate differing accounts of the same phenomena and to understand the nuanced ways in which different contexts, situations, tools, people and interactions shaped this. Thick descriptions of the settings and phenomena observed were also included as a means to situate findings within the context and different circumstances in which data was gathered (Geertz, 1973). Such descriptions also helped to ground interpretation of participants’ accounts in relation to wider social norm, e.g. situating participants’ perceptions of ‘race’ within wider historical, political and academic understandings of ‘race’.

I analysed qualitative data alongside descriptive statistics of the overall matches made at each clinic (outlined further below) which enabled comparison of participants’ discourses and with their material practices and contextualisation of each of these data sets. The identification, reviewing and refining of emergent themes was predominantly undertaken by hand. Whilst I found NVivo useful for organising and retrieving data I found it less useful for undertaking in-depth analysis and this much

of this manually. I used a range of paper materials (from sticky labels to large flip charts) and coloured pens to explore links, patterns and variability within and between the coded data, themes and sub-themes, to develop key emergent concepts.

As noted by Braun and Clarke (2006), data cannot be analysed in an epistemological vacuum and researchers should make their epistemological assumptions explicit.

Although themes were derived from the data they were also informed by the theoretical frameworks chosen before entering the field. The main theory utilised was (bio)medicalisation theory, which informed the use of concepts such as ‘medicalisation’, ‘consumerism’, ‘stratification’ and (to a lesser extent) ‘racialisation’. ‘Sensitising concepts’ provide analysts with a general sense of reference and direction in which to look, rather than prescriptive guidance on what to see (Patton, 2015).

These concepts were related to the research questions and included: ‘matching’, ‘classification’, ‘allocation’, ‘recipient preferences’, ‘recipient selection practices’, ‘recipient agency’, ‘welfare of the child’ ‘race’ and ‘ethnicity’. The research questions framing this thesis too were refined during the research process in order to provide a detailed, nuanced and coherent examination of a particular phenomenon, i.e. the matching process.

The writing up of this thesis was an integral part of the analytical process, as acknowledged by Braun and Clarke (2006). This process was shaped by constraints of space and time, as well as the processes outlined above. Several decisions were made in the writing up of this thesis, including: defining the scope of matching-related themes, the presentation and organisation of findings and which themes to include or exclude. It was tempting to explore the organisation of egg donation more generally in the clinics, particularly as I had accumulated a lot of data on this, and to locate ‘matching’ within this wider framework. However, I felt that this would have diluted the specific insights gained by putting matching at the central focus of study.

Furthermore, I felt that this is what previous researchers had done and I wanted to contribute new understandings to the existing literature. A large array of coding and analysis were not used for the purposes of this thesis, including themes and codes which did not specifically enhance or relate to understanding of matching, e.g. clinicians' differing constructions of kinship with donors and recipients and recruitment and screening of donors and recipients.

I made the decision to organise the empirical findings chapter according to four overarching categories: clinicians' classification of donors and recipients, clinicians' allocation of donors, recipients' preferences for donor characteristics and recipients' practices of accepting/declining donors. There were overlapping themes across these categories, for example in recipients' preferences of exclusion and their practices of declining donors (see Appendix 8). These decisions were informed by the existing literature, the research questions and the endeavour to represent the complex nuances in the different stages of matching as a process.

When writing up the themes I found the need to draw on wider theoretical concepts. Sometimes these concepts added to analysis by helping to understand and contextualise findings and sometimes my findings also illuminated or developed aspects of the pre-existing concepts in different ways. Sometimes, when no specific concepts to explain the meaning that participants attached to their actions and interactions or the consequences of this were available, I developed some 'new' concepts based on existing literature and participants' accounts (e.g. 'kinship risk' and 'marked whiteness').

3.7.2 Descriptive Statistics

At both clinics I collated information about the matches that I had observed, although this process was undertaken differently at each clinic. This included the ethnicity and physical characteristics of matched donors and recipients, whether the matches had been accepted or declined by recipients and their reason for declining donors (when given). At The Fertility Centre, only the 'ethnicity', height and weight of matched donors and recipients was obtained (for the reasons outlined earlier in this chapter). This information was deductively coded from observational field notes of donor allocations (Boyatzis, 1998) and put into a separate excel spreadsheet for each clinic.

Before undertaking analysis I cleaned the data to make it more manageable and consistent. Each donor and recipient was assigned a code, making it possible to distinguish individual donors and recipients with similar characteristics, and data were checked for accuracy with the clinics' own records. Each clinic used different categories for recording donors and recipients characteristics and so it was necessary to re-code data to higher order categories for consistency.

For example, one clinic used the categories 'light brown' and 'dark brown' to classify hair colour whilst the other clinic merely used 'brown', and so these categories were all coded under 'brown'. Another example is the classification of 'ethnicity', where ethnic categories were haphazardly and inconsistently used between and within clinics; thus 'Indian', 'Pakistani', 'Bangladeshi' and 'Sri Lankan' were recoded to 'Asian'. It is recognised that the racialised category of 'Asian' is contentious and that it loses the nuances of differences between individuals within this categories.

However, this category reflected the use of 'ethnicity' by clinicians and recipients, enabled comparative analysis and where relevant differences within these categories are made clear.

Microsoft Excel was used to analyse the extent to which the ‘ethnicity’ and physical characteristics of donors and recipients matched. Each category (e.g. blue, green, brown) within each characteristic (e.g. eye colour) was compared and coded for sameness and difference, where the number 1 indicated same and 0 indicated difference. To compare height/weight differences, recipients’ height/weight was subtracted from their matched donors’ height/weight (with + indicating that recipients were bigger than donors and – indicating that recipients were smaller than donors). Descriptive statistics, i.e. Average, Median, Mean, Mode and Maximum, were then applied to this coded data. These statistics were reported and contextualised within the wider data. At Creative Fertility, I additionally documented whether each match had been accepted or declined by donors. Using the numerical code assigned to individual donors I counted the number of times that donors had been accepted or declined by the first recipient they were matched with and the number of times that individual donors were declined, enabling insight into donors’ that were most excluded by recipients.

Analysis of this data enabled longitudinal insight into clinicians’ and recipients’ material practices and patterns of matching over time and comparison and contextualisation with their discourses. That is, this information showed the outcome of the material practices of clinicians and recipients (separate from their negotiations and discourses). However, some caveats are necessary to note about their use. Firstly, this study is primarily a qualitative study, framed by an interpretive paradigm, and so the meaning of numbers not as important as the meaning behind them (gained through qualitative methods). Secondly, having observed the subjective, contingent and socially constructed nature of how clinicians’ classified patients’ characteristics these categories are not taken to be objective or valid in and of themselves. However, they were included because of their importance in enabling insight into clinicians’

practices (via clinicians' own recording mechanisms) and contextualising qualitative findings from a different level of analysis.

3.8 Research Rigour, Trustworthiness and Quality

The evaluative criteria of 'reliability' and 'validity' are central to quantitative research. These are seen as protecting the research and its findings from criticisms of 'bias' and as quality assurance measures (Golafshani, 2003). 'Reliability' refers to the replicability of research findings using the same methodology. Joppe (2000: 1) defines reliability as: "The extent to which results are consistent over time and an accurate representation of the total population under study". 'Validity' refers to the accuracy of the research (Joppe, 2000; Babbie, 2015), including the extent to which the research measures what it intended to (construct validity), coherence between data and theory (internal validity) and the generalisability of research findings beyond the immediate research context (external validity) (Trochim et al., 2015; Bryman, 2016).

Given the different paradigms which these two approaches subscribe to the question of how 'reliability' and 'validity' should be assessed in qualitative research is the source of much debate. Whereas quantitative research is concerned with manipulation of phenomena under study, causal relationships between variables, prediction, hypothesis, statistics and generalisability, qualitative research is concerned with meaning, understanding phenomena in-depth in the settings in which they naturally occur. Thus, whereas quantitative analysis takes more of a deductive 'top-down' approach and seeks to test a pre-existing hypothesis quantitative analysis is more inductive, exploratory, 'bottom-up' and 'data driven', allowing theory to emerge from the data itself.

Some scholars argue that researchers should endeavour to replicate these principles of validity and reliability in qualitative research (Patton, 2001) whilst others have been critical of these criteria and argue that they do not apply to qualitative research in the same way (Lincoln and Guba, 1995; Strauss and Corbin, 1990). This latter group of scholars instead propose other criteria to replace these concepts, such as:

‘trustworthiness’, ‘credibility’, ‘sensitivity’, ‘commitment’, ‘transparency’
‘coherency’ and ‘rigour’ (Lincoln & Guba, 1985; Seal, 1999; Golafshani, 2004; Shenton, 2004; Nowell et al., 2017).

A commonly referenced framework for evaluating qualitative research is that proposed by Lincoln and Guba (1985), in which they also proposed techniques for achieving these criteria. The four pillars of this framework are: Credibility, Confirmability, Dependability and Transferability. ‘Credibility’ refers to the ‘truth value’. It is similar to the concept of ‘internal validity’ in positivist terms and refers to the coherence between data collected and theory generated. Techniques for achieving credibility include: prolonged engagement, persistent observation, triangulation, peer debriefing, member checking and negative case analysis. Confirmability in qualitative research is less about researchers’ efforts to maintain neutrality and freedom from bias (as in quantitative research) than about researchers’ efforts to engage with the phenomena under study, ethically and in ‘good faith’. To achieve this, Lincoln and Guba (1985) advocate research reflexivity, triangulation and an audit trail (i.e. the transparent and explicit description of the steps taken throughout the research process).

Dependability refers to the ‘reliability’ of research. However, in qualitative research, this is less about whether research findings can be replicated than whether the research process was coherent, transparent and consistent. To the end, Lincoln and Guba (1985) suggest providing an “inquiry audit”, i.e. having an external researcher

examine the process and findings of the research. Transferability refers to the ‘applicability’ of research findings to other contexts, and is most similar to ‘external validity’ and generalisability in the positivist paradigm. Lincoln and Guba (1985) suggest that providing a ‘thick description’ of the so that one can evaluate to what extent research conclusions are applicable to other settings, times, situations and participants. Below, I will discuss the steps taken to ensure the quality, rigour and trustworthiness of this research by addressing Lincoln and Guba’s (1985) 4 criteria.

One of the benefits of using ethnography is that it enables researchers to use multiple methods through which to explore a single topic. The findings and theory generated in this thesis were triangulated between data methods, e.g. interviews, observations and clinic documentation, between different participants, e.g. clinicians and recipients and between 2 field sites. The long-term duration of observations also enabled me to verify findings longitudinally, to contextualise phenomena within the wider context of the clinic and to build rapport and trust with participants, encouraging them be more open and honest in their interactions with me. The systematic recording of information about a large number of matches at each clinic also enabled comparison of participants’ discourses and with material practices; the accuracy of quantified information was checked with clinics’ own recorded before analysis. The findings of this thesis are also coherent with the findings of research on donor-recipient matching in transnational and international contexts of egg donation.

The process of designing the research, fieldwork, data analysis and interpretation, were discussed confidentially with my supervisor, with scholars in the field and, where possible, with clinicians and recipients during fieldwork. Efforts were made to undertake all stages in this research process reflexivity, inclusively and ethically. I critically engaged with the process of research, noting down personal reflections, discussing my experiences, reflections and emergent findings confidentially with my

supervisor and peers and shared emergent themes with participants. An audit trail of the choices made in different stages of this thesis and the reason for making them has been detailed so that they could be traced and re-evaluated. My own interests in the research topic, the purpose of the study, and methods used to recruit participants, collect data and analyse data were made transparent and explicit, as were the inferences made.

The small size of this study and the rapidly changing field of egg donation through techno-scientific, policy and organisational developments limit the applicability of the findings of this research to other contexts. For example, since fieldwork was undertaken there has been an increase in egg freezing, the importation of donor eggs and websites enabling recipients to choose their own donor, all of which shape the organisation of matching and did not feature in this study. The different organisational dynamics of other fertility clinics in different parts of the UK might also limit the extent to which the findings of this study might be applicable elsewhere.

This study was intended to be in-depth and as such the sacrifice of having limited transferability was accepted from the outset. However, the thick description of the research settings, participants, methodology used and data gathered enable external evaluation of the ways in which the research context shaped the findings and conclusions of this study, and the extent to which these conclusions may be transferable to other time periods, settings, participants and situations.

3.9 Summary

This study follows a constructionist approach and used an ethnographic approach to explore the organisation of matching and the perceptions and practices of clinic and recipients in the context of two private fertility clinics in South East England.

To enable this, the research methodology adopted multiple data collection methods namely observations of consultations and clinical practices, clinicians interviews, recipients interviews as well as available documentation on and about the clinics. These methods not only allowed a rich collection of data but also supported triangulation and a deeper understanding of the ways in which perspectives and practices were linked (and not linked) and related (and not related) to each other. The ethical considerations, sampling and recruitment methods, sample characteristics, data collection methods and data analysis method pertaining to this study were also outlined, as were my own selective reflections on the experience of fieldwork. Finally, processes of quality assurance in qualitative research as they applied to this study were discussed. The next chapter will provide the background and context to the empirical findings of this thesis (presented in Chapters 5-8).

Chapter 4: The Regulatory and Clinical Context of Matching

4.1 Introduction

This chapter provides the background to the wider regulatory and immediate clinical settings in which this study was undertaken. It provides the context to the findings of this study and draws attention to the highly regulated nature of the UK context of egg donation, in which it is argued that regulation is a driver of medicalisation and limits the commercialisation of egg donation.

The organisation of egg donation and matching differ significantly across different countries, and indeed within individual countries and clinics. This includes differences in the public funding of Assisted Reproductive Technologies (ARTs), legal definitions of parenthood and the regulation of donor screening, anonymity, donor payment, patient access to treatment and the welfare of the child, to name a few. The different organisation of egg donation in each country reflects the politico-economic context and socio-cultural values of that country and illuminates the peculiarities of a particular context.

In some countries, such as Germany and Norway, egg donation is prohibited (Bergmann, 2011), whilst in other countries access is organised differently. In France, the majority of ART cycles are funded by the State but access is limited to married heterosexual couples (Fournier et al., 2013) whilst in Israel the state funds unlimited egg donation cycles irrespective of marital status or sexual orientation (Birenbaum-Carmeli, 2016). In the USA on the other hand, as in several countries with provisions for ARTs, egg donation is organised according to the free-market and access is restricted to those who can pay (Barney, 2005; Almeling, 2007; Glennon, 2012). In

the UK, there is a mixed picture of private/public funding of ARTs, although the majority of egg donation cycles are privately paid for; restrictions to recipients' access to private and NHS funded treatment come from the state, healthcare commissioners and the medical profession (as will be shown below).

Such contrasts are also revealing when considering the macro-level organisation of matching in different countries. For example, in the USA recipients can select their own egg donor (Becker, 2000; Almeling, 2007) whilst in Spain and Finland clinicians have a mandatory duty to match the 'ethnicity' and physical characteristics of donors and recipients (Kroløkke, 2013; Bergmann, 2015; Homanen, 2018). The regulation of matching in the UK has changed over time, as will be explored below. The USA context of egg donation in particular will be drawn upon below because it provides such a stark point of comparison with the UK context.

The chapter will begin by outlining the regulatory context of ARTs and egg donation in the UK, where this study took place, and provides a historical overview of regulation on donor-recipient matching in gamete donation. This will be followed by a description of 'matching' – as defined for the purposes of this study and informed by ethnographic fieldwork. Finally, the organisation of each clinic and the organisation of matching in each clinic will be outlined, with attention to the differences between each clinic.

4.2 Regulation of Egg Donation in the UK

The regulatory context of egg donation is particularly significant in shaping the organisation of matching in the UK context and provides some of the background to the research questions which emerged in this thesis. The UK context of gamete donation is highly regulated, centralised and medicalised. The UK government has

taken what has been described as a “communitarian approach” (Glennon, 2012) towards fertility treatment in that it has sought to safeguard the interests of society and children born from fertility treatment and has developed legislation through numerous public consultations and reviews (Pfeffer, 1993; Thompson, 2005; MacInnes and Diaz, 2009).

This approach is in sharp contrast to the organisation of egg donation in the USA, for example, where individual autonomy, privacy and commerce are prioritised over the state intervention and in which there is a minimalist approach to federal (and sometimes state) regulation and no public funding for ARTs (Thompson, 2005; Almeling, 2007; Glennon, 2012). Thus, unlike in the USA, where the regulation of ARTs is predominantly left to the medical profession and the market, in the UK ARTs are regulated by the medical profession and the state (Barney, 2005; Thompson, 2005; Sargent, 2007; Glennon, 2012). The size of the market in the US and UK contexts are also significantly different. The growing US fertility market is estimated to be worth more than \$3.5 billion [££2.8 billion] (Harris Williams & Co, 2015) whilst the UK fertility market estimates the UK fertility market to be worth around £320 million (Risebrow, 2018).

The main principles underlying the UK’s regulatory framework of ARTs are based on the recommendations of the Warnock Committee, who published their findings in what is commonly known as ‘Warnock Report’ (Warnock, 1984). The Warnock Committee saw regulation as fulfilling a normative function, for the “protection of the public”, to safeguard the welfare of children born through ARTs and to ensure the ‘moral regulation’ of ARTs. The main legislation governing egg donation has been the Human Fertilisation and Embryology (HFE) Act (1990), which put into practice many of the Warnock Committee’s (1984) recommendations. In mid-late 2000, ART legislation and regulation was subject to major reforms which accumulated in the

updated HFE Act (2008), introduced to consolidate previous amendments and new updates to the HFE Act (1990). Several public consultations and reviews were commissioned by the HFEA and the Department of Health (DoH) to inform the development of regulation (DoH, 2003, 2005b; HFEA, 2005a; HFEA, 2005b).

The HFE Acts (1990, 2008) extensively regulate a range of ethical, legal, socio-cultural, ethical, techno-scientific, biomedical and economic aspects of ARTs. Under the provisions of the HFE Act (1990) the responsibility for implementing, overseeing and enforcing ART regulation and relevant legislation falls to the Human Fertilisation and Embryology Authority (HFEA). The HFEA is the UK's independent arm's length statutory regulator for fertility treatment which defines one of its primary roles as being to balance and protect the "conflicting interests" of clinics, intending parents, donors, donor-conceived persons and society.

The HFEA's main responsibilities are to license, monitor and inspect fertility clinics in the UK, to set standards for good clinical practice and to interpret legislative requirements for fertility clinics. By law, all fertility clinics operating within the UK, both NHS and private, must have a HFEA license to practice (which the HFEA has the power to grant and revoke), for which they must follow HFEA guidance and use standardised forms to record and submit information to the HFEA. Together, state legislation and the HFEA regulate a range of ethical issues in relation to gamete donation, including: informed consent, legal parenthood, donor compensation, donor anonymity, disclosure, the welfare of the child, the screening of donors and the procurement, handling, storage, transportation and transfer of donor gametes.

Under UK law, all aspects of the egg donation process are under the jurisdiction of licensed fertility clinics and clinicians have state-sanctioned monopoly over the procurement, provision and use of donor eggs (Wikler and Wikler, 1991) which has

protected them from external market forces. Furthermore, only fertility treatment undertaken in HFEA licensed fertility clinics are covered by the provisions of the HFE Act (2008) thus making legal definitions of parenthood through gamete donation inherently medicalised (Winkler and Winkler, 1991); the legal rights and protections afforded to donors, recipients and donor-conceived persons under UK legislation would not automatically apply to the exchange of gametes outside of the UK state-sanctioned clinical context, e.g. to sperm donation at home or egg donation abroad. Unlike in the US, where recipients of donor eggs are required to employ external lawyers and can pay a mediating egg donation agency thousands of dollars in addition payments for donors and treatment costs, in the UK legal paperwork and the ‘supply of donors’ are undertaken ‘in-house’ by clinics themselves (although this latter point is changing).

Since the introduction of the HFE Act (1990) it has been a criminal offence in the UK to buy or sell human gametes. However, the Act (1990) does allow for donors to be “compensated”, and in turn, the HFEA stipulates that egg donors may be remunerated £750 or through “benefits in kind” per treatment cycle. This latter option generally entails women taking part in ‘egg sharing’ arrangements, where a woman ‘donates’ half of her eggs to a recipient and in returning for using the other half in her own heavily subsidised treatment. Currently (since 2005) the state mandates that donors must be identifiable to persons conceived of their donation from the age of 18 (HFE Act, 2008). This is based on ‘welfare of the child’ considerations, which in the current era of regulation, are defined by the state as knowing one’s ‘genetic origins’ (DoH, 2005b). This is contrary to previous legislation in which donors were permanently anonymous and the state framed identifiable donors as a threat to the donor-conceived families (Warnock, 1984). This is in sharp contrast to the USA, where donors can remain anonymous and are reported to have been paid in excess of \$50,000 [£37,000],

with “premier” donors with ‘desirable’ characteristics commanding higher sums (Glennon, 2012).

It has been argued that the regulatory context of the UK, where legislation limits donors’ financial autonomy and their right to privacy, has led to a shortage of egg donors, whilst countries in which the free-market determines issues in egg donation, where there is no state restriction on the payment to donors and donors remained anonymous, have enabled a higher supply of donors (Craft et al., 2005; Pennings, 2005; Glennon, 2012). In the USA for example, third party commercial ‘egg brokers’ have emerged as a niche service to recruit and ‘sell’ donors to recipients (Mamo; 2005; Almeling, 2011; Glennon, 2012). In the UK on the other hand, regulation over the provision of donor gametes (which favours the authority of the medical profession) and the limit to donor compensation have discouraged the emergence of such third party commercialised agencies. Nonetheless, it is important to note too that despite concerns about the impact of regulation on ‘donor supply’ the number of egg donors in the UK has increased since 2006, which the HFEA have put down to an increase in compensation limits and public awareness of gamete donation (HFEA, 2014b).

Access to publicly funded treatment is restricted at different levels. At a macro level, Clinical Commissioning Groups (CCGs), which have been responsible for commissioning healthcare since 2013, have restricted, reduced or stopped the provision of NHS fertility treatment altogether, thus exacerbating the ‘post-code lottery’ in healthcare and stratifying (bio)medicalisation. For example, most CCGs exclude women over 36 years old, women with existing children and women with a high BMI from accessing NHS funded treatment. Bearing in mind that two-thirds of recipients of donor eggs in the UK are women over the age of 40 (HFEA, 2014b) this has meant that most recipients are forced to use the private sector. Thus in the UK the

vast majority of gamete donation treatment cycles in the UK are funded by private paying (HFEA, 2014b).

However, whilst recipients' ability to pay to access egg donation is necessary it is not sufficient. This is because the HFE Act (1990), like the Warnock Report (Warnock, 1984) before it, focused on a moralised conceptualisation of *restricting* patient eligibility for treatment based on social welfare of the child considerations. This translated into meso-level constraints on recipients' access to fertility treatment, which placed a duty on clinicians to make social judgments, not just medical judgements, about a person's access to treatment on the basis of their perceived 'suitability to parent' (Douglas, 1993; Malin, 2003; Campbell, 2007). Set out in Section 13(5) of the HFE Act (2008) is a small clause mandating that clinicians take into account the welfare of any child born through ARTs before providing intending parents with treatment. Currently, the HFE Act (2008) mandates:

"A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting)" (HFE Act, 2008: 13(5)).

Previously, the bracketed clause of the need to take into account a child's need for 'supportive parenting' specified a child's 'need for a father' (HFE Act, 1990: 13(5)). Thus, the HFE Act (1990) inherently discriminated against lesbian couples and single women from accessing gamete donation. As such, scholars have argued that legislative (and therefore state) discourses concerning the 'welfare of the child' have been an attempt to regulate parenthood and procreation in accordance with wider societal and state assumptions about who or what makes a family based on an ideology of the family as heterosexual, two parent, white and middle class (Haimes, 1992; Pfeffer, 1993; Franklin, 1997; Campbell, 2007).

Whilst acknowledging clinicians' legitimate discretion in making "social judgements that go beyond the purely medical" (Warnock, 1984: 2.13) the Warnock Committee (1984) nonetheless drew attention to the importance of the moral and legal framework of reproduction and the need to ensure that clinicians' autonomy did not lead to a radical departure from that framework. According to some, the state's vested interest in reproduction is exerted and visible through its regulation of ARTs which it legitimises as being in the interests of the 'public' and the 'welfare of the child' (Robertson, 1991; Pfeffer, 1993; Franklin, 1995; Steinberg, 1997; Roberts, 1999; MacInnes and Diaz, 2005; Thompson, 2005; Campbell, 2007; Wade, 2007; Apel, 2008).

Although on the one hand clinicians' mandatory obligation to consider the welfare of the child might be interpreted as limiting their professional autonomy by regulating their decision-making, on the whole scholars have argued that the 'welfare of the child' has been used by clinicians to legitimise their discretionary decision-making and social judgements about reproduction (Steinberg, 1997; Roberts, 1999; Malin, 2003; Culley et al., 2004; Campbell, 2007). Thus, as highlighted by Szkupinski-Quiroga (2007: 148), in the US context of gamete donation, "because of their mastery of biomedicine, physicians in particular have culturally sanctioned authority that extends to reproduction". However, Lee et al. (2014) have argued that although legislated welfare of the child considerations have been seen as a prime example of medicalisation the gatekeeping role of clinicians has more of a reality in law than in practice.

Whilst the UK context of egg donation shares some aspects of neo-liberal ideology (e.g. rolling back of state funding) it does not share them all. In the UK, there is high state intervention through regulation, the nature of which limits the free-market, prioritises societal and children's welfare over individual reproductive autonomy and

shapes the roles of stakeholders in the egg donation process (Barney; 2005; Glennon, 2012). Findings from current studies on matching in transnational and international contexts cannot therefore be uncritically applied to the UK context, where egg donation is highly regulated, there is a shortage of egg donors and medical professionals have a mandatory obligation to consider the welfare of the child. In this respect, the political-economic context of egg donation in the UK reflects that of the British “regulatory state” (Walshe, 2002), in which state expansion and intervention increasingly takes place through regulation and less through funding and provision (Majone, 1997, Levi-Faur, David, 2011). According to Tanzi (2002: 121), “one could almost speak of a regulatory welfare state, since many countries have pursued their social objectives not through public spending or tax expenditure but through regulation”.

4.3 HFEA Policy on Matching

The emphasis on the neo-liberal context of matching in previous studies of gamete donation warrants some attention to the regulatory and policy context of the UK, specifically as it relates to matching. Having explored the general regulation surrounding ARTs and egg donation more widely (above), this section provides the historical and regulatory context for *matching* in gamete donation specifically and the key rationale behind the development of this research, through which the present findings in the following chapters can be framed and understood.

The Warnock Committee (1984) and the HFE Acts (1990, 2008) both stood silent on the topic of donor-recipient matching. Between 1991-2007, the HFEA had two policies related to matching in place, ‘Cytomegalovirus (CMV) matching’ and ‘ethnic and phenotypical matching’ (HFEA, 2003). Although the nature of HFEA matching

policies has changed over time there has been an inherent assumption throughout these changes that it is clinicians who will allocate donors to recipients and mediate recipients' selection of donors, i.e. that matching will take place under medical jurisdiction. A shortage of egg donors in the UK has necessitated the allocation of these donors to recipients by a mediating agency. The two HFEA matching policies and their implications for clinicians' autonomy and recipients' autonomy will be discussed below, with focus given to 'ethnic matching'.

It is important to note here that, as shown above, in the UK the wider regulatory context of egg donation has thus far precluded the market from significantly threatening the dominance of the medical profession over the recruitment – and allocation – of donors to recipients (the global organisation of ARTs and cross-border reproductive travel aside). Therefore, the main threat to clinical autonomy in matching has been from regulation rather than from the market. This is in contrast to the USA, for example, where third party commercial agencies have “outhustled” the medical profession from this role (Glennon, 2012: 101; Almeling, 2007) and, given there is provision for recipients to choose their own donor from an online catalogue of donors, have access to a range of in-depth information about donors and pay more for donors with 'desirable' characteristics (Barney, 2005; Almeling, 2011; Glennon, 2012). The implications of this regulatory context for matching are discussed below.

4.3.1 Cytomegalovirus Status Matching

Although it has been given little attention in sociological literature, historically the HFEA has required fertility clinics to match donors and recipients by their Cytomegalovirus (CMV) status. CMV is a common (predominantly dormant) virus and it is estimated that well over 50% of the adult population in the UK are CMV

positive (NHS, 2018). If a pregnant woman is CMV negative and is exposed to the CMV virus during pregnancy there is a risk that the foetus will become infected and develop “congenital CMV”. Whilst most of these babies do not exhibit any problems it is estimated that a small number of infants will be symptomatic at birth and face some long-term health problems (NHS, 2018).

It was due to this relatively small risk of foetuses developing congenital CMV that the HFEA demanded that egg and sperm donors be matched with recipients according to their CMV status. Therefore, this policy was rationalised as being in the welfare of children born through egg donation (HFEA, 2003). As with the screening of donors more generally, the above policy revealed the state’s aim in ensuring that ARTs reproduced particular types of children, i.e. healthy children. In doing so, this policy restricted CMV negative recipients’ access to donors.

4.3.2 ‘Ethnic’ Matching

Historical HFEA Policy on ‘Ethnic’ Matching

Commentators on the HFEA’s matching policy have predominantly focused on the stipulation that clinicians ‘ethnically match’ donors and recipients (Millns, 1995; Price, 1997; Culley, 2005; Culley et al., 2004; Campbell, 2007; Wade, 2007; Wade, 2012). However, the implications of this policy went beyond prescribing how donors should be allocated to recipients, as will be shown further below.

In the 6th Code of Practice (2003-2007), the HFEA stipulated a policy which stated:

"Centres should strive as far as possible to match the physical characteristics and ethnic background of the donor to those of the infertile partner unless there are good reasons for departing from this.

When discussing the selection of potential donors, centres should be sensitive to the wishes of those seeking treatment for information, whilst avoiding the

possibility that this information could be used to select a donor possessing certain characteristics for reasons that are incompatible with or not relevant to the welfare of the child. For example, those seeking treatment should not be treated with gametes provided by a donor of a different physical resemblance unless there are compelling reasons for doing so." (HFEA, 2003: 3.18-3.19 (underline added))

In the 7th Code of Practice (HFEA, 2007), following the recommendations of a HFEA Review (HFEA, 2005b) and as part of a wider overhaul of HFEA policy, the HFEA removed its policies on CMV matching and ethnic matching, as will be outlined further below on 'Current HFEA Policy'. First, the development of historical HFEA policy on 'ethnic matching' will be explored immediately below, including what this revealed about the state's conceptualisation of normative families, and its intention to reproduce them, and the implications for the clinical autonomy and patient (recipient) agency.

Normative Reproduction: Clinicians as Gatekeepers of the State

For the first couple of years since its inception (1991-1993) the HFEA stipulated that clinicians should match the physical characteristics of donors and recipients as "good clinical practice" (HFEA, 1991). From the 3rd – 5th Code of Practice (1995-2003) the HFEA still required clinicians to match the physical characteristics of donors and recipients but removed reference to this as 'good clinical practice'. The 3rd Code of Practice also introduced the characteristic of 'ethnicity' as an overt consideration in matching for the first time, thus beginning the formal legacy of 'ethnic matching' in egg donation by mandating that clinicians prohibited recipients from choosing a donor of a different 'ethnicity' to themselves. In the 6th Code of Practice (HFEA, 2003), presented just above, the HFEA intertwined clinicians' role in matching with their mandatory responsibility to take into account the social welfare of children born from gamete donation for the first time.

In doing so, the HFEA re-framed the rationalisation for ‘ethnic matching’ from being a scientific standard (“good clinical practice”) to being an ethical standard (‘welfare of the child’). Prior to the implementation of this policy, a letter from the HFEA to clinics advising them of the update to the 6th Code of Practice originally used the term “racial origin” (HFEA, 2002) (see underlined in the excerpt above), which was replaced with “physical characteristics” when implemented in the Code of Practice (HFEA, 2003). Although this was a small change, it reflected a more general populist orientation in conceptualising ethnicity as a physical characteristic whilst moving away from the overt use of racial terminology. The use of ethnicity in inverted commas in this thesis indicates such ambiguities surrounding its use. In this policy, the HFEA defined the welfare of the child as best being met by a normative ideology of the family in which parents and children shared the same ‘ethnic’ background and physical characteristics.

As such, a lack of ‘racialised resemblance’ was framed as harmful to the welfare of the child and as requiring intervention by medical professionals, thus positing them as ‘agents of the state’ (Steinberg, 1997) and restricting their clinical autonomy to match donors and recipients. However, the HFEA did allow clinicians a degree of discretion in their gatekeeping role by permitting them to depart from this practice where they saw “good” or “compelling” reasons to do so, although it provided little guidance as to what constituted a “good” reason.

HFEA policy on ‘ethnic matching’ has been criticised by a range of scholars, who have argued that this policy was tantamount to reproducing a ‘state sponsored racialised ideology of the family’ (Campbell, 2007). According to Szkupinski-Quiroga (2007), the practice of ‘ethnic matching’ reinforces a dominant heteronormative ideology of the (white) family whose members physically resemble each other on account of being the genetic offspring of each parent. Scholars have drawn

parallels between the imposition of ‘ethnic matching’ at a macro level and historical state intervention into reproduction and ‘race’, i.e. American miscegenation laws and attempts at maintaining ‘racial purity’ and preventing ‘racial cross-mixing’ (Roberts, 1999; Fogg-Davis, 2001; Campbell, 2007: 113; Szkupinski-Quiroga, 2007).

According to Campbell (2007) HFEA ‘ethnic matching’ policy “smacks of eugenics”, whereby state-sponsored medicalisation serves to reproduce normative racialised boundaries of the family. HFEA policy has also been criticised for reproducing the discrimination faced by mixed ethnicity families by explicitly preventing their reproduction (Wade, 2012). The main focus in the literature on egg donation has been on the above ‘ethnic matching’ policy, which according to Wade (2012), seeks to reproduce ‘racially congruent families’.

Constraining Recipient Agency

In the early days of policy, the HFEA required clinicians to “take into account” recipients’ “preferences” for donor characteristics, thus prescribing a degree of agency to recipients (HFEA, 1991). The 3rd Code of Practice (HFEA, 1995) introduced the first of a series of constraints on recipient agency in the matching process. More specifically, the HFEA prohibited recipients from choosing a donor of a different ethnicity to themselves “for social reasons alone” and placed clinicians in the gatekeeping role of ensuring this was adhered to.

The 6th Code of Practice (HFEA, 2003), outlined above, continued the trend of curtailing recipient agency in the matching process, defined here as the ability to choose a donor of a different ‘racial origin’ to themselves. In framing ‘ethnic matching’ as a welfare of the child concern the HFEA simultaneously framed the welfare of the child as in direct opposition to recipient agency and required clinicians to make decisions in favour of the latter.

This framing of recipient agency as needing to be restricted reflected the view of the Warnock Committee (1984: 4.21) which concluded that recipient choice in donor selection should be limited “as a matter of principle” and as a welfare of the child concern. The 6th Code of Practice (2003) stated that clinicians should merely “be sensitive to the wishes” of recipients in relation to “donor information”. This subtle change of wording reflected a subsequent shift in the HFEA’s conceptualisation of recipients’ agency, diverting attention away from recipients’ active agency in choosing the characteristics of their donor towards recipients’ passive agency in ‘receiving information’ about donors. This shift became solidified in successive Codes of Practices.

After HFEA policy on matching was removed, the HFEA continued with its earlier re-conceptualisation of recipient choice from being ‘active’ to being ‘passive’ and focused its attention on recipients’ right to receive non-identifying information about their donor (HFEA, 2007). Previously, the HFEA had only defined recipients’ access to information in relation to informed consent, i.e. in relation to clinicians’ obligations to inform recipients about the nature and implications of treatment. However, after 2007, the HFEA also placed a duty on clinicians to provide recipients with non-identifying information about their donor, including donors’ ethnicity, basic physical characteristics, year and place of birth and hobbies, a ‘good-will message’ and ‘pen-portrait’ (HFEA, 2009). Although HFEA policy has increased recipient’s potential agency through increasing the amount of information that they can receive about donors it has also curtailed recipient agency by defining this in relation to their access to information rather than the right to choose their donor.

As illustrated above, the policy of ‘ethnic matching’ was about far more than reproducing a racialised ideology of the family, although this was an important facet of it. HFEA policy on matching also mandated that clinicians act as ‘agents of the

state’ and ‘agents of women’s reproduction’ (Steinberg, 1997) in managing recipients’ preferences and ensuring they did not challenge the existing moral order of reproduction and kinship (Warnock, 1984). Thus this policy constrained recipient agency by restricting their choice of donors according to their ‘ethnicity’ and as a consequence stratified their access to treatment (Culley, 2004; Millns, 2005).

Current HFEA Policy

In 2014, some 7 years after the removal of HFEA policy on ‘ethnic matching’ and CMV matching, the HFEA introduced the general guidance requested by the SEED Review (HFEA, 2005b) which has remained in place to the present day. In a stark departure from previous policy (before 2007) the HFEA advises clinicians that they are no longer expected to ethnically match donors and recipients and that if a recipient is willing to accept a donor of a different ethnicity then ‘transracial matching’ would be acceptable (HFEA, 2014a). From 2014 to the current time (mid-2018), HFEA matching policy states:

Centres are not expected to match the ethnic background of the recipient to that of the donor. Where a prospective recipient is happy to accept a donor from a different ethnic background, the centre can offer treatment, subject to the normal welfare of the child assessment. (HFEA, 2014a: 11.16)

Unlike previous HFEA policy on matching, which constrained clinicians’ autonomy, current HFEA policy re-validates clinicians’ discretionary autonomy and dominance in matching by stipulating that they no longer have an obligation to ‘ethnically’ match donors and recipients. On the surface, the current guidance appears to afford recipients a degree of agency in matching by enabling them to accept a donor of a different ‘ethnicity’. However, unlike earlier HFEA policy on matching which recognised recipients’ ‘active agency’ (in choosing a donor of a different ethnicity), albeit whilst trying to constrain it, current HFEA policy appears to frame recipients’

agency in a passive way (recipients' willingness to accept a donor of a different ethnicity because of a shortage of donors). Furthermore, the acceptability of this agency is still subject to clinical discretion, as clinicians must be willing to match recipients with a donor of a different 'ethnicity' in the first place.

Despite the removal of policy on 'ethnic matching' a brief perusal of UK clinic websites reveals that fertility clinics match donors and recipients by 'ethnicity' and physical characteristics. As noted previously, the present study was undertaken during the period of policy absence on matching (2013-2014). All clinics in the UK are subject to the same national legislation and policy regulations. However, there has been little exploration into how different clinics organise matching within this regulatory framework. It was seen as important to investigate how clinicians matched donors and recipients, entirely at their own discretion, and the impact of the regulatory context on clinicians' and recipients' practices.

Having outlined the wider regulatory context and examined how it shapes the organisation of matching in the UK, before going on to present the empirical findings of this thesis, it is important to additionally contextualise the findings of this thesis in the immediate contexts in which they were explored. Below, the nature of matching as a process will be defined followed by an overview of the two fertility clinics in this study and the organisation of matching within them.

4.4 Overview of the Matching Process and Two Field Sites

Both of the clinics that took part in this study were subject to the national regulation outlined above. However, fieldwork across both clinics revealed nuanced similarities and differences in relation to the structure of each clinic and the way in which each clinic organised matching, and in particular in relation to the process, procedures,

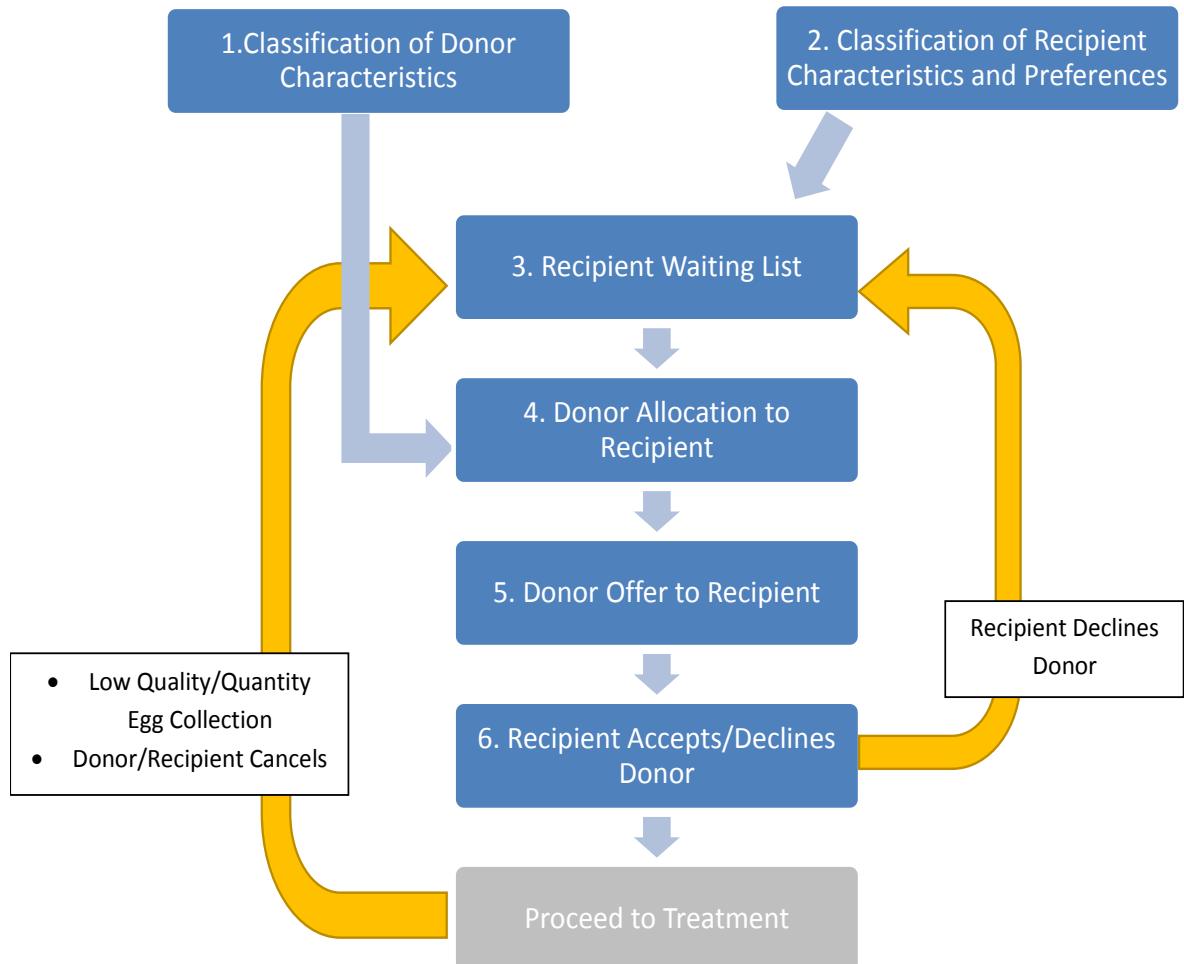
policies and practices of matching. Before going on to outline some of the differences between the two clinics in this study and how they each organised matching, the concept of matching will be defined. Fundamentally, for the purposes of this study, matching is defined as a *process*.

4.4.1 The Matching Process

‘Matching’ has commonly been depicted as a single practice, i.e. the selection of donors by clinicians or by recipients. However, ethnographic fieldwork for this study revealed matching to be a process, which can be broken down into 6 interdependent stages. Conceptualising matching as a process enables insight into how different sets of aims, activities, decisions, trajectories, roles, tools, constraints, perceptions and interactions combine to result in particular outcomes. The organisation of matching is thus mediated by and reliant on several stages, which were revealed through the course of fieldwork and data analysis.

These stages, presented in Figure 4.1 below, involve: (1) Classification of donor characteristics (2) Classification of recipient characteristics and recipient preferences for donor characteristics (3) Management of the recipient waiting list (4) Allocation of donors to recipients by clinicians (5) Offering of donors to recipients by clinicians (6) Recipients’ acceptance or refusal of offered donor(s). Both of the clinics in this study structured the matching process according to these stages. Although other important stages in the egg donation process also took place around these stages (e.g. screening of donors and recipients) they were excluded from the matching process.

Figure 4.1 The Matching Process



Although the overall process of matching at each clinic (Figure 4.1) was similar, the procedures of matching in each were significantly different, as will be outlined below.

4.4.2 Organisation of Matching in 2 Fertility Clinics

Both of the clinics in this study shared similar attributes; they were private clinics which undertook egg donation, based in the Southeast of England and were subject to the same national regulatory framework (outlined above). However, fieldwork at each clinic revealed important differences between the two clinics in this study, including in relation to their organisational cultures, structures and demographics. The culture of each clinic refers to the shared assumptions, values and beliefs which shape individuals' actions and behaviour and the taken for granted norms of an organisation (Parker et al., 2008; McLean, 2013). The organisational structure of each clinic refers to size, the materials used, the roles of staff and the procedures employed with clinics (McKenna, 2000; Jones, 2013), particularly in relation to the organisation of egg donation and matching. The size of each of these clinics refers to the number of staff, patients and treatment cycles undertaken at each clinic.

Despite both of the clinics in this study organising the matching process according to the stages outlined above (Figure 1), each did so in distinctly different ways. These differences are important for situating the empirical findings in the following chapters. The organisational features of each clinic and their respective organisation of the matching process are outlined below.

Creative Fertility

The first clinic at which fieldwork was undertaken was 'Creative Fertility', a large, stable, and well-established clinic. The clinic was founded and managed by Mrs Redwood and a partner, who opened the clinic in the early 1990s. The clinic was defined as a "large treatment centre" by the HFEA; in the year of fieldwork (2013),

Creative Fertility undertook around 1,500 treatment cycles, about 150 of which involved cycles of egg donation, and employed around 35 members of clinical and administrative staff, including 3 doctors, 8 nurses and a team of 8 embryologists.

The stability of the clinic was reflected in its low staff turnover (most staff had been with the clinic for over 5 years) and formal/bureaucratic organisation. Because Creative Fertility was a large and well-established clinic it had formalised internal policies and procedures in place, such as electronic systems for recording and managing large sets of patient information. Clinic staff undertook specialised roles, e.g. different nurses worked on different stages of the egg donation and matching process and clinicians' roles were clearly demarcated. Therefore, recipients typically saw different nurses during their visits to the clinic (as they moved through the egg donation process).

Most of the clinicians who worked on the egg donation programme at Creative Fertility were white and came from outside the UK. Anna and Jemma (the nurses responsible for matching) were from Australia and Mrs. Redwood (Director) was from the Netherlands and used to manage and undertake matching in the past. Doctor Demetrious was from Turkey and Doctor Ali was British Indian, and both saw donors and recipients for their 'Initial Consultation'. Reflecting the picture of donors and recipients nationally, most of the recipients were white British middle-class women over 40. Most of the donors were also white British/white other. Of the 150 matches observed at the clinic 90% comprised white British or white other donors and recipients whilst 10% of these donors and recipients came from BME backgrounds.

Matching at Creative Fertility

The large number of patients at Creative Fertility required matching to be managed in a formal, de-centralised and systematic way, which included having defined staff

roles, systems and processes. The matching process at Creative Fertility was organised using electronic systems. Electronic forms were used to record donors' and recipients' characteristics and recipients' preferences for donor characteristics, a tailor-made database was used to allocate ('match') donors to recipients, and donors were offered to recipients remotely via e-mail.

Decision-making authority was de-centralised and staff had specialised roles. The Directors of the clinic, who had a financial investment in the running of the clinic, were not directly involved in the matching process. The clinicians who undertook matching were salaried employees, within a large clinic, and so did not have a direct financial investment in the matching process (i.e. encouraging recipients to accept donors). The classification of characteristics was undertaken by doctors (Doctor Ali and Doctor Demetrius), the allocation of donors to recipients was nurse-led and undertaken by 2 nurses (Anna and Jemma) and a doctor (Doctor Ali), and the offering of donors to recipients was undertaken by the above 2 nurses. As the different elements of the matching process were undertaken by different clinicians, it was typical for donors and recipients to encounter different clinicians at different stages of the matching process.

The practice of donor allocation ('matching') took place in regular weekly 'matching sessions'. Clinicians typically made around 4 matches a week and recipients, where they matched and offered a single donor at a time to recipients. Recipients waited around 6 months to be matched with a donor. Typically, the waiting list for a (white) donor was in excess of 25 recipients. However, for donors with certain characteristics, i.e. BME donors and white donors with particular characteristics, the number of recipients on the waiting list much shorter, often between 3-7 recipients, reflecting the number of recipients who were willing to accept donors with those characteristics.

The Fertility Centre

The second clinic at which fieldwork was conducted was ‘The Fertility Centre’, a smaller and newer clinic than Creative Fertility. Established in 2011, the clinic was founded by Doctor Rana, the Director of the clinic, with support from partners. In the year of fieldwork (2014) the clinic undertook fewer than 300 treatment cycles, 50 of which were egg donation cycles (a third of egg donation cycles undertaken at Creative Fertility). The clinic employed around 7 members of staff, including 1 doctor, 1.5 nurses and several Health Care Assistants (HCAs), who were employed to undertake non-technical care work.

The small size of the clinic and its relatively recent inception meant that the internal organisational structure was not well established and there were few formal policies and procedures in place. The clinic primarily relied on paper forms and patient files to maintain patient records. The informal structure and culture of the clinic meant that staff roles were not clearly defined and a shortage of doctors and nurses meant that individuals were often expected to “use initiative” and to undertake duties above their pay grade, e.g. HCAs were commonly asked by senior management to undertake clinical nursing duties. The instability of the clinic’s culture was also reflected in its high staff turnover; during the period of observations 8 new members of staff joined the clinic and all 8 left.

The clinic had a self-defined ethos of providing ‘personalised patient care’ and ‘continuity of care’ to patients, which clinicians felt was made possible due to the small size of the clinic. Typically, Doctor Rana and Noreen dealt with patients throughout their egg donation journey. The recently established nature of the clinic meant that it was still trying novel ways to market itself in the growing industry of fertility clinics in the UK (and globally). The commercial strategies employed by the

clinic to promote its services included branded merchandise, such as pens and baby grows, discounts for consultations, and advertising in social media orientated towards BME women (such as Asian magazines and radio shows).

The clinicians who worked on the egg donation programme at The Fertility Centre were predominantly BME; Noreen was Chinese and from Malaysia and Doctor Rana was British Indian. Other staff (e.g. HCAs, managerial and administrative), who were not directly involved in matching, came from an equal mix of white ‘other’ (e.g. European and Australian) and BME backgrounds. The ethnicity of donors and recipients was also more mixed than at Creative Fertility; this feature of the clinic not only differentiated it from the other field site, but also from samples of recipients in previous studies on egg donation in the UK (Konrad, 2005; Klotz, 2014). From the 65 matches that were made at the clinic, just over half involved BME recipients (58%) followed by white recipients (42%) and just under half involved BME donors (40%) compared with white donors (60%).

Matching at The Fertility Centre

At The Fertility Centre, the small size of the clinic meant that the organisation of matching was based on a more informal approach. The Fertility Centre took a “personalised” approach to matching, which relied on a small number of staff, their tacit knowledge, and paper forms (contained in patient files). Paper forms were used to record donor characteristics and recipient preferences, to allocate donors to recipients, and to offer donors to recipients via a face-face consultation.

The different elements of the matching process were undertaken by a single nurse, Noreen. However, decision-making authority was centralised to the extent that donor allocation was sometimes undertaken, and always authorised, by Doctor Rana (Director). As the only full-time doctor and nurse at the clinic, these clinicians

typically saw all of the patients who attended the clinic. As the founder of the clinic, the Director had a vested financial interest in the running of the clinic, and in the matching process, which was especially apparent given the clinic's small size.

On average, the clinic made one match a week, although these matches were undertaken sporadically over the period of observations. The small number of matches made meant that matching could be undertaken "casually" within the clinic and was not given allocated time as a defined task. Although some matches took place during a scheduled 'matching session', the majority took place outside of any formalised sessions, during informal meetings or by the Doctor or Noreen in isolation.

At The Fertility Centre, recipients were often matched with a donor within 3 months of joining the clinic's waiting list for donors, and sometimes well within a month. Despite having a shortage of egg donors relative to recipient demand, on the whole, the disparity between the supply and demand of donors and recipients was less than at Creative Fertility. The size of the waiting list of recipients was much shorter at The Fertility Centre. Typically, there were fewer than 10 recipients on the waiting list for a donor at any one time. On some rare occasions, the clinic had donors to match but no recipients on the waiting list for those donors. The existence of a 'frozen egg bank' at The Fertility Centre also contributed to the short waiting time for recipients, as recipients could be allocated a donor instantaneously and did not have to spend time going through treatment with donors.

4.5 Summary

This chapter has outlined the wider regulatory background and immediate clinical contexts in which this study took place. The UK context of egg donation was shown to be highly regulated, in which the welfare of the child is a central organising

principle and used to reproduce a normative moral order and model of the family. The nature of regulation reinforces medical professional jurisdiction and dominance (and sometimes challenges their autonomy) whilst limiting the degree to which egg donation is commercialised and arguably has translated into a shortage of egg donors and long recipient waiting lists for donors. HFEA policy on ‘ethnic matching’ has changed over time, moving from an emphasis on the ‘welfare of the child’ to recipients’ access to treatment.

The conceptualisation of matching as a process, rather than a single practice, was put forward, and the stages within this process were outlined. Although both of the clinics in this study followed the same high-level matching process each clinic had different organisational procedures for undertaking matching. The two clinics in this study each had distinct organisational features and matching procedures; Creative Fertility was a larger clinic which took a more bureaucratic, arguably paternalistic, approach to the organisation of matching whereas The Fertility Centre was a smaller clinic and took a more personalised and informal approach to matching.

In the literature recent studies have explored how the constraints of the UK regulatory context as ‘push’ factors leading to recipients going abroad for treatment (Hudson et al., 2011). However, few studies have explored the impact of regulatory constraints on recipients’ perceptions and practices within the UK clinical context. This study seeks to fill this gap by exploring the impact of context on the organisation of matching at a meso- and micro-level. The following four empirical chapters will explore the different stages that comprise the matching process alongside clinicians’ and recipients’ perceptions and practices, beginning with clinicians’ classification of donors and recipients into categories (Chapter 5).

Chapter 5: Clinicians' Classification of Donors and Recipients

5.1 Introduction

Classification is a central component of stratification; the categories that individuals are ascribed to determine their access to resources and shape their identity and experiences. Shim (2014) has highlighted the importance of exploring how the 'mechanisms for sorting people become mechanisms for stratifying them'. That is, she advocates exploring how difference is made meaningful through classification (as will be the focus of the current chapter), and then to explore how we then act on those beliefs (the focus of the next chapter). In order to explore how matching is undertaken, it is important to understand how clinicians categorise donors and recipients beforehand. This is because stratification 'boils down' to two powerful mechanisms: "the allocation of people to social categories, and the institutionalization of practices that allocate resources unequally across these categories" (Massey, 2007; 5-6).

Clinicians' classification of patients has been explored in studies of 'race' and ethnicity (Miles, 1989; Sheldon and Parker, 1992; Smaje, 1996) and the healthcare literature more generally (Bradby, 1995; Nazroo, 1997; Aspinall, 2005; Bhopal, 2007). However, few scholars have explored how clinicians classified donors' characteristics for the purposes of matching (Fox, 2008; Costa, 2009; Thompson, 2009; Bergman, 2015; Schurr, 2016) and hardly any have explored the ways in which clinicians classified recipients' preferences for donor characteristics. Some studies have reported that clinicians sought to influence recipients' preferences for donors of a different 'race' (Roberts, 1999; Jones, 2005; Szkupinski-Quiroga, 2007) although

few of these studies explored the ways in which this was undertaken in practice (Bergmann, 2015; Deomampo, 2016).

Classifications or categorisations are spatial and temporal. According to Bowker and Star (2000: 10), “a classification is a spatial, temporal or spatial-temporal segment of the world”. Classification involves categorising things into “a set of boxes” which then do some kind of work. Classification systems are simultaneously conceptual, contextual and political and can shift historically. The classification of human beings into racial categories is particularly contentious, especially in relation to ‘race/ethnicity’ and skin tone. Such classifications are entrenched in wider histories of colonialism, eugenics, slavery, imperialism and racism where they have been used to segregate human beings according to a racial hierarchy of skin tone and justify the inferiority of non-white people and the superiority of white people (Miles, 1989; Gilroy, 2000b; Thompson, 2009; Hudson, 2015).

Such classificatory systems are inherently intertwined with the “creation of stigma and racialised ideas about people from hot climates” (Rodriquez (2011: 423). In the literature on ‘race’ and ethnicity, whiteness has traditionally been posited unmarked, invisible and the norm whereas those from minority ethnic backgrounds have been posited as marked, visible and other (Jackson, 1998, Tyler, 2007; Frankenberg, 2001; Hudson, 2015). As highlighted by Stoler (1995), for example, the categories of “Indians” and “whiteness” were created (when) to establish and sustain a particular colonial social and political order.

In this chapter, I will explore how clinicians classified donors’ and recipients’ ‘ethnicity’, physical characteristics and social characteristics, how clinicians shaped the classification of recipients’ preferences for donor characteristics, followed by

clinicians more implicit classification of recipients as ‘good’ or ‘demanding’ based on recipients’ behaviour and clinicians’ expectations of the recipient role.

5.2 Classification of Physical and Social Characteristics

Although primarily collected for the purpose of matching donors and recipients, the classification of donor information served multiple purposes within the clinic. Firstly, anonymised donor information was also provided to recipients to use as a ‘donor selection tool’ to decide whether to accept or decline a donor. Secondly, clinics were also required to submit donor information to the HFEA so that donor-conceived persons could access it in the future.

At Creative Fertility, electronic template forms were used to record the characteristics of donors, recipients and recipients’ partners. These electronic forms contained a list of pre-existing characteristics (e.g. eye colour) and tick-box categories (e.g. blue, brown). The pre-existing list of categories meant that clinicians and recipients were restricted to the characteristics and categories used by the clinic. At The Fertility Centre, paper forms were used to record donors’ (and sometimes recipients’) characteristics. Although the forms contained pre-existing characteristics (e.g. hair colour), the responses were filled in as free-text, by hand, by the nurse.

Despite the different tools used, both clinics recorded similar information about the physical and social characteristics of patients. The characteristics recorded by clinicians included: ethnicity, skin tone, eye colour, hair colour, height, weight, religion, occupation, education and hobbies/interests. For donors, clinicians also recorded their motivation for donation and asked them to fill-out a ‘pen-portrait’ (self-description) and ‘good-will’ message for persons born from their donation. At both clinics, the forms contained a free-text box in which clinicians’ recorded additional

information about patients' characteristics. The characteristics and categories used at each clinic were based on the HFEA Donor Information Form (see Appendix 9). Despite having the option of categorising donor characteristics as free-text at The Fertility Centre, in practice, the categories used by the nurse generally correlated to the categories used at Creative Fertility

Nonetheless, despite the standardised characteristics used for recording patients' (donors' and recipients') characteristics, in practice, the process of classification was not a straightforward and neutral practice of ascribing objective categories to measurable characteristics. Rather, the characteristics recorded were the outcome of: clinicians' perceptions of patients, patients' perceptions of themselves, how clinicians posed questions to patients, how patients responded, and the responses that were recorded by clinicians. Thus, this section will show how the classification of donors and recipients into different categories highlights the subjective, medicalised and racialised nature of classification. In the following chapter, the ways in which these classifications determined which donors and recipients could or could not be matched together will be explored.

The classification of donors and recipients into physical and social characteristics is a mechanism of differentiation; donors and recipients are reduced into individual categories so that they can be re-assembled in medically sanctioned ways (i.e. during allocation and offering). In this section, the process by which clinicians' grafted the properties of donors and recipients onto physical and social categories of differentiation (Thompson, 2005) will be explored. Below, the problematic nature of classifying patients' physical and social characteristics will be explored, followed by clinicians' classification of patients' 'ethnicity' and skin tone.

5.2.1 Physical Characteristics and Hobbies

On the whole, clinicians described the process of recording patients' physical and social characteristics as "easy" and "straightforward". When labelling patients' physical and social characteristics, sometimes clinicians posed open-ended, closed-ended or leading questions to patients and sometimes they simply asked patients for confirmation of their own inferences. Sometimes patients responded to clinicians' questions about their own characteristics with confusion and ambiguity, and sought clarification from the doctor, their partner, and even from me.

For example, when asked about their hair/eye colour, some (white) patients replied that these characteristics were changeable depending on the lighting of their environment/different seasons of the year, and some patients replied with a mixture of colours across or outside of the available categories (e.g. strawberry blonde hair colour). On one occasion, a donor had one green colour eye and one blue colour eye. In such cases, clinicians asked recipients to arbitrarily select a single category (at Creative Fertility) or wrote in an amalgamation of multiple categories as free-text (at The Fertility Centre), e.g. 'greeny blue' eye colour.

The height and weight of patients was recorded as free-text at both clinics, with BMI being worked out electronically. Although it might well be assumed that the height and weight of patients were accurately and reliably recorded given the categorical nature of these categories and the availability of measuring equipment, sometimes clinicians filled in this information by merely asking patients about their current height and weight. If patients responded that they did not know, clinicians sometimes extrapolated patients' height from a visual comparison with their own height or recorded the outcome of verbal deliberations between the recipient and her partner. Clinicians paid little regard to ambiguities around patients' physical characteristics, and instead concentrated on ensuring that the forms were filled in in a timely manner.

The classification of donors' hobbies and interests was also inherently shaped by clinicians. When enquiring about patients' hobbies and skills, clinicians would first pose this as an open-ended question to patients, such as 'what are your hobbies and interests?' The recording of these social characteristics was more laboured for donors than for recipients, and if the information disclosed by donors was deemed too little, clinicians would ask more closed or leading questions, such as whether the donor enjoyed 'travelling' or 'cooking', or whether they 'played a musical instrument'. Often donors were recorded as playing the 'recorder' or 'piano', despite them not having played in over a decade.

5.2.2 'Ethnicity' and Skin Tone

Unlike the physical and social characteristics of donors (listed above), the process of classifying the ethnicity and skin tone of donors and recipients was more complex and involved clinicians differentiating patients into different categories through a process of racialisation. This process of ascription was not merely a case of 'asking patients the question and noting down their reply' (as some clinicians saw it), but was the outcome of clinicians' own beliefs and assumptions about skin tone, 'race', and genetic inheritance, and their interaction with these and other socio-technological categories.

The 'race'/ethnicity of donors and recipients are used as primary matching criteria by clinics and are therefore recorded in all clinics globally (Costa, 2007; Thompson, 2009; Ariza, 2015; Hudson, 2015). The classification of 'ethnicity' and skin tone by fertility clinics has been subject to much criticism from scholars (Pennings, 2000; Fogg-Davis, 2001; Szkupinski-Quiroga, 2007; Costa, 2009; Thompson, 2009). As highlighted by Gunaratnam (2003: 19):

“The conceptual ‘fixing’ of ‘race’ and ethnicity is dangerous... because it can serve to produce and reproduce wider forms of essentialism, stereotyping and racism.”

Studies have explored how clinicians classify the physical and social characteristics of predominantly white donors and recipients in egg donation in Brazil (Costa, 2007), Argentina (Ariza, 2015), the USA (Almeling, 2007), India (Deomampo, 2015) and Spain (Bergmann, 2015), all of which found that clinicians classified donors and recipients ‘ethnicity’ based on their own perceptions of skin tone. For example, Bergmann (2015) found that clinicians in Spain generally classified women from Northern Europe as ‘white’ but would also classify women as “Mediterranean” if they thought they “looked Spanish”. However, there have been no empirical studies of clinicians’ practices of classification in the UK context of gamete donation.

In the following sub-sections the focus will be on how clinicians’ operationalised the ethnicity and skin tone of patients and on the material processes and mechanisms by which clinicians stratified patients into different ‘ethnic’ and skin tone categories.

‘Ethnicity’

During the period of observations, Creative Fertility based its ethnic categories on the 1991 Census despite the HFEA recommending ethnic categories based on the 2001 Census at the time of fieldwork. The categories available for recording ethnicity at Creative Fertility were: White British; Black African, Black Caribbean, Black other; Indian, Pakistani, Bangladeshi; Chinese; and Any other ethnic group. The categories of ‘any other white’, ‘any other Asian’ and ‘black’ were also available on the clinic’s database, but were seldom used or used with very little consistency in classification. Despite the option of recording patients ethnicity as free-text, the nurse at The Fertility Centre also relied on the above categories, in addition to using general and

specific racial and ethnic categories, such as “Caucasian”, “Black”, “Oriental”, “Asian”, “Indian” and “Gujarati”.

The use of generic categories such as “Caucasian” and “Black” is troublesome because of the historically contingent and politicised nature of these categories. Whereas the UK Census ethnic categories were intended to measure ethnicity as cultural identification, despite the criticisms levelled against them for conflating ethnicity, nationality, ‘race’ and skin tone (Ahmad and Sheldon, 1992; Aspinall, 1997; Modood et al., 1997), both clinics used ethnic categories primarily for the purpose of physical differentiation. Clinicians said they felt ‘restricted’ and “frustrated” by the availability of ethnic categories, which they saw as unsuitable for the purposes and patient population of their clinics. This view is illustrated by Noreen, at The Fertility Centre (who ironically classified ethnicity as free-text):

“I think those are the only categories anyway. Because we are bound by the HFEA and those are the only categories that we can give. But there are times, sometimes I really get frustrated.” [Noreen, The Fertility Centre]

The increasing trend towards fertility tourism has meant that increasing numbers of recipients are seeking fertility treatment, from outside of the UK’s traditional immigrant population, in UK fertility clinics. Although most donors were UK based, some donors were from abroad and attended the clinic whilst on a UK work or student visa. Thus, the 1991 Census categories, designed to reflect the ethnic diversity of the UK population (at that time) (Sillitoe and White, 1992), were not always able to accommodate the diverse ethnicities and nationalities of patients at each of the clinics. Neither clinic used the specific ‘Ethnicity Codes’ recommended by the HFEA at the time (although these Codes had also changed during the course of fieldwork).

Clinicians found it particularly difficult to classify “white” patients from countries outside of the UK. At both clinics, patients from a range of countries, cultures and ethnicities were assigned to the generic and homogenous category of “white” based on clinicians’ perception of their skin tone. This included women from Afghanistan, Algeria, Iran, Brazil, Chile, Columbia, the Middle East, Russia, Saudi Arabia and countries in Europe. As illustrated by the quote below from Doctor Ali, clinicians saw the category of ‘white’ as so broad that it became almost meaningless:

“They’re quite restrictive [the ethnic categories]. ‘Cause we were trying to work out, ideally, like we’ll get some patients who are from North Africa, and they are white or whatever, and if we get somebody who’s Middle Eastern, just, everything will be white [...] I don’t think the database has anything saying mixed race, or middle eastern” [Doctor Ali, Creative Fertility]

In order to differentiate between ‘types’ of white donors, clinicians recorded additional information about patients’ ethnicity as free-text, e.g. ‘Bulgarian’. That is, clinicians ‘marked’ the ethnicity of white patients from outside of the UK by recording additional information about their ethnicity/nationality/skin tone. No additional information was generally recorded for white British patients, unless additional information was disclosed by patients which clinicians deemed worth recording, e.g. about their genetic ancestry (e.g. grandparents’ ethnicity) or place of birth. For example, 2 white British donors were ‘marked’ when they disclosed having a “Maltese grandmother” and a “half-Tunisian grandmother”.

This ‘marking’ of ethnicity also took place when there was a disparity between donors self-identified ethnicity and clinicians’ perceptions of donors’ skin tone, which they saw as a primary indicator of donors’ ethnicity. In this respect, clinicians conceptualised ethnic classification as a visual skill, which involved undertaking further investigation to discern donors’ “natural” and ‘genetically inheritable’ skin tone, as illustrated by the quote below from Doctor Ali:

“I saw one donor and she said that she was white British, but then I asked her, because I looked at her skin colour, and I said ‘Is that your natural skin colour?’, and it was olive. And then she said, ‘Well actually my grandmother has done an ancestry chart or something like that and they found out that she was from Romany Gypsies’.” [Doctor Ali, Creative Fertility]

In such cases, clinicians would classify patients as ‘white’ and record the outcome of their investigations as free-text, e.g. “Romany Gypsy grandmother”. Previous studies which have explored clinicians’ categorisation of ‘whiteness’ in transnational contexts of egg donation (Costa, 2007; Ariza, 2015; Almeling, 2007; Schurr 2016; Bergmann, 2015) and of skin tone in South Asian donors in India (Deomampo, 2016) have reported that clinicians classified donors according to their own perceptions of skin tone. However, none of these studies were undertaken in the UK and so were unable to capture the specific nature of classification within this context, such as the categories available for classification and the factors influencing the process of ascription to these categories.

Clinicians’ perceptions of skin tone and ‘race’ also impacted how they classified patients, as did the availability of ethnic categories that they had access to. For example, The 1991 ethnic Census categories did not have a category for ‘Arab’ or for ‘mixed ethnicity’ and so in the absence of such categories, clinicians allocated patients to ethnic categories based on their own perceptions of skin tone.

Thus, depending on a clinicians’ perception of a recipients’ skin tone, an Arab woman could be classified as “black African” or as “white” (from observations). In both cases, these classifications were ‘marked’ with additional free-text information to qualify the ambiguity of the classification. For example, an Arab recipient who was classified as “black African” was additionally described as “light-skinned Arab” and an Arab recipient classified as “white” was additionally described as “Arab”. These additional ‘markings’ were used to signal to clinicians that the patients were

something other than their classification indicated so that they could be allocated an ‘appropriate’ donor (explored further in Chapter 6). This process of categorising patients according to their skin tone also illustrated that minority ethnicity could also be marked (to reference the ‘lighter’ skin tone of BME patients), which was also evident in clinicians’ categorisation of mixed ethnicity patients.

When classifying the ‘ethnicity’ of mixed ethnicity patients, clinicians assigned these patients to their minority ‘non-white’ ethnicity. This classification would be marked by additional comments about patients’ particular ‘racial mix’ e.g. “Indian and Caucasian”. This process of classification was undertaken at both clinics. However, unlike at Creative Fertility, the nurse at The Fertility Centre additionally described the ethnicity of mixed ethnicity individuals as percentages in the free-text box, e.g. one donor was labelled as being “50% White British, 25% Caribbean and 25% Indian” and was ultimately classified as BME (black Caribbean). Such descriptions gave the idea that ethnicity could be broken down and assigned a quantitative value, by medical professionals, thus reinforcing ideas about “race” and ‘purity of races’ (Duster, 1990; Stoler, 1995; Wade, 2007) and contributing to the medicalisation of ‘race’ and ethnicity (Witzig, 1996; Santiago-Irizarry, 2001; Morning, 2011).

Clinicians’ categorisation of mixed ethnicity individuals as non-white (BME) also illuminated their underlying conceptualisation of white ethnicity as ‘unmarked’ and BME ethnicity as ‘marked’, reflecting more traditional understandings of racialised markedness (Frankenberg, 2001). That is, clinicians appeared to conceptualise ‘non-white’ ethnicity as visible and genetically dominant, and therefore needing to be labelled, whilst ‘white’ ethnicity was seen as unmarked, invisible and genetically recessive, and therefore was not a ‘risk’ needing to be marked but something needing to be protected. Therefore, clinicians sought to categorise mixed ethnicity donors as

‘non-white’ rather than ‘white’ so that this could be taken into account during matching (i.e. to prevent these donors being allocated to white recipients).

However, as illustrated above, clinicians also marked the ethnicity of some white donors, illustrating that the process of ethnic marking was not restricted to BME patients. Clinicians thus marked the skin tone of some white donors through their classification of donors and recipients into different categories of skin tone, as will be shown below.

Skin Tone

Both clinics used pre-existing categories to record patient’s skin tone which were based on the HFEA Donor Information Form (Appendix 9). These categories were “Light/fair”, “Medium”, “Olive”, “Freckles” and “Dark”. At The Fertility Centre, nurses also recorded patients’ skin tone as an amalgamation of different categories or using different categories altogether, e.g. “medium-dark” or “light brown”. The role of clinicians in categorising patients’ skin tone has been subject to criticism by researchers, who have challenged clinicians’ ability and authority to undertake this process by virtue of their medical training (Fogg-Davies, 2001; Thompson, 2009: 132). As with the classification of patients’ ethnicity, the ascription of skin tone categories to patients was not a straightforward and objective process but was based on clinicians’ racialised perceptions of skin tone.

Unlike with the labelling of other physical characteristics, clinicians saw the nature of ascribing skin tone to patients as “difficult” and “contentious”. However, despite acknowledging the inherently “controversial” and subjective nature of classifying patients’ skin tone clinicians nevertheless felt that they were best placed to undertake this classification. Thus, in practice, clinicians’ perceptions of skin tone took precedence over patients’ own self-identification, as illustrated by the quote below

from Doctor Demetrious who was responding to my question about how he classifies patients' skin tone. Initially, the doctor responded by asking me to label my own skin colour, to which I replied "medium":

Doctor Demetrious: "So you think your medium. I think you are more than medium. Is medium more than olive? Less than olive? What is olive? So this is extremely difficult to understand. Because for someone Swedish you are dark. So I have to say it's very difficult. It's something controversial. It's very difficult to debate whether you are medium or you are light. No, I usually put that in myself, what I think, because I don't think it makes much sense"

PD: "If you had asked me as a patient? ..."

Doctor Demetrious: "You wouldn't know. There is no way. So that particular one I put in myself. It's very ethnically sensitive" [Doctor Demetrious, Creative Fertility]

As illustrated by the quote above, clinicians classified patients' skin tone in relation to their ethnicity. South Asian and black African/Caribbean patients were often labelled as having 'medium' or 'dark' skin tone, regardless of their own self-identified skin tone, as illustrated by the quote below from Doctor Ali:

"A lot of Asian women will say they're light, but they're medium. So a lot of them I'd say were medium, there's only ever one that I'd say I'd really seen who was light skinned but the rest of them I'd say were probably medium." [Doctor Ali, Creative Fertility]

White patients on the other hand were typically labelled as having "light/fair" skin tone, which clinicians described as a standard process of enabling some uniformity in the matching process (e.g. not differentiating between types of white donors to the extent of hindering a match being made). However, when this standard practice was at odds with clinicians' perceptions of patients' skin tone they sought to determine and record patients' "natural" skin tone, i.e. , i.e. generally inheritable skin tone. For white patients clinicians commonly used 'ability to tan' as an indicator of their 'natural skin

tone'. This process was more laboured for donors than for recipients, for whom clinicians sought to discern their 'natural' and genetically inheritable skin tone.

Here, clinicians' conceptualisation of 'natural white skin tone' was shaped by the UK context, and its climate. That is, in the context of the UK clinicians conceptualised 'natural' white skin tone as 'light' and 'untanned' (and unmarked) due to the colder climate, whilst 'naturally "tanned" or "olive"' (marked) white skin tone was attributed to patients from countries with 'warm and sunny' climates such as southern Europe and other countries in the southern hemisphere. As such, in the context of the UK, clinicians saw 'light' skin tone as providing the baseline for 'natural'/'normal' white skin tone. Conversely, clinicians saw 'naturally tanned' skin tone, or a "forever tan", as needing to be identified and 'marked' (rather than classified as 'light'), as illustrated by the quotes below from Anna and Noreen:

"But with White British it's quite difficult because we live in the UK and it's not always very warm and sunny, so you don't see a lot of tanned people. So you know, we have to sort of have to gauge that. When we say 'fair skinned', for white, that's the majority. But if a patient's really... then we can ask the donor, to what extent...Do you tan easily?" [Anna, Creative Fertility]

"Yeah, because you base it on their ethnicity. If they are Caucasian and dark, it means that they tan easily, so sometimes you write 'Olive' because they tan easily or they have a forever tan and stuff like that [...] it's hard to quantify it." [Noreen, The Fertility Centre]

The 'marking' (labelling) of white patients was predominantly focused on patients with 'darker features'. Although there was no ethnic category for 'Mediterranean' patients, clinicians commonly used this informal category to describe donors and recipients from a range of regions, including southern Europe, the Middle East and Northern Africa. Clinicians conceptualised 'Mediterranean type' patients as sharing similar physical characteristics, i.e. 'olive skin', 'dark hair' and 'dark eyes', as

illustrated by the quote below from Mrs. Redwood. In this regard, Mediterranean type' patients can be seen as the archetype of 'marked white' patients.

“So we find donors who are Mediterranean in terms of type, but they come from Cyprus, or they come from Iran, Morocco, or Libya, you know, living in the UK [...] donors who are really Mediterranean looking, olive skin and uh, dark hair, and eyes.” [Mrs. Redwood, Creative Fertility]

According to Brekhus (1998: 35), the very act of naming/labelling a category simultaneously constructs *and* foregrounds that category; when something is 'marked' it is qualified as a specialised form that needs to be distinguished from its more “generic” form. Such markings involve a social process whereby certain groups are rendered more visible than others, often in negative ways (Snyder, 2015).

In the remainder of this thesis I will use the term 'marked whiteness' to refer to those white donors and recipients who had literally been 'marked' in the clinic by having additional information recorded about their ethnicity, skin tone, wider kin, nationality and place of birth and who were thus differentiated from the more generic category of whiteness, i.e. white British with light skin tone. Such markings were undertaken to signal that patients were something other than their ethnic classification indicated. This practice of 'marking' was not generally undertaken for white British patients who fitted clinicians' perceptions of 'normal whiteness' in the context of the UK.

5.3 Classification of Recipient Preferences

The tools used to classify recipients' preferences for donor characteristics at each clinic were similar to those outlined above at each clinic (e.g. electronic forms and paper forms). At both clinics, recipients could state their formal preferences for donors' ethnicity, skin tone, eye colour and hair colour. At The Fertility Centre,

recipients could also state their preferences for donors' height, weight, religion and educational/professional level. At both clinics recipients could also state additional informal preferences for donor characteristics as free-text. As with the classification of donor/recipient characteristics, the recording of recipients' preferences was undertaken by a clinician.

Clinicians emphasised recipients' ability to state their preferences for donor characteristics and to decline donors as central sources of agency for recipients in the egg donation process. According to clinicians, recipients' ability to have some choice in selecting their donor enabled recipients to feel like they had some "control", "comfort" and "reassurance" about their donor in a context within which their donors were otherwise anonymous and selected on their behalf by clinicians. This view is illustrated by the quotes below from nurses at each clinic:

"Well, I guess it's the recipient, they've got a bit more control in terms of who they can choose, as such, although they don't have any idea, we're doing it all. But I think it would be quite difficult as a recipient not to have any involvement at all, or not have a clue about who this person is. At least they have some idea, or, you know, some control over what they may look like, what they do, or whatever they're looking for in a donor" [Jemma, Nurse, Creative Fertility]

"I can't blame them. I can't judge them as well. I can't blame them, the way that they want to design the baby. Because this is the only control that they have" [Noreen, The Fertility Centre]

However, clinicians saw a limit to the agency that recipients should exercise within the matching process. They had expectations of the type and amount of agency that recipients should exercise and undertook strategies to pathologise and intervene in cases where recipients' behaviour disrupted these expectations. Although clinicians saw the aim of matching as being to meet recipients' preferences for donor

characteristics, they had expectations of what these preferences should be and shaped recipients' preferences accordingly, as will be outlined below.

On the one hand, clinicians expected recipients to have a preference for a “suitable donor”, which in the context of egg donation referred to a donor with the same characteristics as themselves, as illustrated by the quote below from Doctor Rana:

“First of all it is the patient’s requirement, what she wants, and then we feel happy that we found a donor suitable for her. Like we matched to somebody who looks like her and all” [Doctor Rana, The Fertility Centre]

Whilst clinicians were keen to facilitate this preference, as it was concurrent with their own priorities in matching, they also expected recipients to be willing to compromise on their preference for resemblance due to a shortage of egg donors (and donors with a particular mix of characteristics). Therefore, clinicians also expected recipients to be willing to accept donors with different characteristics to their own in order to prevent having delay to their treatment. The quote below from Noreen from The Fertility Centre illustrates this view:

“I think the more specific you are the harder it is to match. The more broad the choices are the more easy to match. You know, the more easier, quicker to match a donor with a recipient. If we specify too much then I think it would take longer. So you have to be willing to compromise. But otherwise it’s going to take a longer process to match” [Noreen, The Fertility Centre]

This expectation was relayed to recipients during their consultations. Despite telling recipients they could request whichever donor characteristics they wanted, clinicians also encouraged recipients to widen their acceptability criteria for donor characteristics to include donors with characteristics which were different to their own. Clinicians framed this compromise as ultimately beneficial for recipients, as a “reasonable” compromise and ‘choice’, which would reduce recipients waiting time

for a donor and actually increase their choice of donors, as illustrated by the excerpt below from an observation of a recipient consultation at Creative Fertility, in which the doctor told the recipient:

“Doctor Redwood: You can specify what you want. You can state the physical characteristics which will be acceptable to you. But the more you choose, the more this will increase the potential donors that are offered to you, it will actually widen your choice. You set the limits. But in our experience we’ve found that if the characteristics you’ve requested are reasonable, the waiting time shouldn’t be too long” [Field notes, Recipient Consultation No. 10, Creative Fertility]

Clinicians also advised BME recipients that they should be willing to compromise on their preference for a donor of the same ethnicity. For example, during recipient consultations clinicians often asked BME (primarily South Asian) recipients whether they would be willing to accept a white donor if no BME donors were available, as illustrated by the quote below from Anna. If recipients refused, clinicians often advised them to go abroad (to India for) treatment, to use a known donor or to be prepared to wait for a long time, as indicated by the quote below:

“It’s less common, we have less donors of other ethnicities [than white] coming through. So the reality is they [BME recipients] are going to be waiting longer, and I think the majority of patients who ... they’re told this at their initial consultation, so I think a lot of them will make a decision at that point that...they don’t want to wait any longer than necessary” [Anna, Creative Fertility]

However, although clinicians expected recipients to accept difference with their donor due to a shortage of donors they did not see it as equally acceptable for recipients to have a specific consumer preference for a donor with different characteristics to their own. Neither were preferences for all types of difference seen as equally acceptable. Clinicians questioned recipients’ motivation for not wanting to match their own characteristics or to reproduce resemblance with their child. In particular, clinicians

pathologised the motivation of recipients who specifically wanted a donor of a different “race” to themselves. They framed such a preference as “demanding”, “unusual” and as an “ethical” concern; this was particularly the case when referring to white recipients requesting a BME donor.

Echoing previous HFEA policy on ‘ethnic matching’, clinicians depicted recipients as having a consumer motivation for wanting ‘racial difference’, which they saw as challenging normative familial boundaries (through ‘choosing difference’ and seeking to enhance their child’s characteristics) and needing to be curtailed to protect the best interests of the child. In such cases, clinicians saw it as their own role to limit the degree of whiteness that recipients could access in their donor, as illustrated by the quote below from Mrs. Redwood:

“I think a patient who decides, who is one type, one race, and decides to have a child of another race from egg donation, has to be completely aware of the consequences, on the child. I think, people do not always have the right idea of what’s going to happen, or have misconceptions, and it’s really to protect the child [...] It’s the same in the African population [as the ‘Indian population’]. Some, a lot of these African ladies want a child that’s as light as possible. But how far light do you go?” [Mrs. Redwood, Creative Fertility]

Clinicians saw recipients who specifically wanted a donor with different characteristics to their own as having a consumer motivation of wanting to ‘improve’ or ‘exotify’ the characteristics of their child, particularly in relation to racial difference. However, different discourses shaped clinicians’ perspective of the acceptability of a white recipient wanting a BME donor vs. a BME recipient wanting a white donor. A common theme in clinicians discourses was that lighter skin tone and fairer features are regarded as more valuable, desirable and “beautiful” within BME communities and so BME recipients therefore wanted to ‘improve’ their child’s characteristics by lightening the skin tone of their child, as illustrated by the quote below from Noreen:

“I think they want a child who is lighter skinned than them, or a mixed child, because in their eyes, in their mind, the child would be beautiful and everything.” [Noreen, The Fertility Centre]

At The Fertility Centre, the Director, who was South Asian, contextualised BME recipients’ preference for a white donor within the wider context of racial discrimination, in which lighter skin tone is privileged and darker skin tone is stigmatised. The Director therefore conceptualised BME recipients’ preference for a white donor, and a child with lighter skin tone, as a protective mechanism employed by recipients to protect their child from discrimination and to facilitate their child’s life chances. As illustrated by the quote below, Doctor Rana saw BME recipients’ preference for a white donor as a strategy for enabling their child to ‘fit in’ to wider (British) society, not merely into their family unit:

“Some of them, they say, ‘well, we are in this country, if our child is fair, it’s a good future for the child’, that’s what they say, they want to give a better life for the child you know [...] We think that is beautiful. So we say that if you have a fairer child, the child will fit into this society” [Doctor Rana, The Fertility Centre]

When asked whether there were any recipient requests that clinicians would not allow, all clinicians said they would not allow a white recipient to request a BME donor. Clinicians had concerns about the motivation of white recipients for wanting to cross what they saw as ‘natural’ racialised boundaries of the family and saw this request as ‘overdoing it’. Clinicians’ opposition to this request is illustrated in the quote below from Doctor Ali:

“I think it probably depends on what the patients want. But you don’t want to overdo it. You can’t have white patients demanding ‘I want to have a black donor’. I don’t think we can do that, I don’t think anyone has ever done that.” [Doctor Ali, Creative Fertility]

Recipients' preferences were recorded by a clinician using the standard forms in each clinic. This meant that clinicians were in the powerful position of shaping, allowing and disallowing recipients' preferences for donor characteristics. In ensuring that recipients' preferences were "ethically correct", clinicians saw it as their role to intervene in and constrain recipient choice if they deemed recipients' preferences were 'abnormal' or "strange". In these cases, clinicians used counselling and ethics committees as disciplinary mechanisms to manage recipients' non-compliant behaviour before allowing them to proceed with treatment. This ethical and disciplinary gatekeeping role was evident in the discourses of clinicians at both clinics, as illustrated by the quotes below:

"If the request is somewhat strange for example, if the recipient wants characteristics in a donor which we think are not normal then we always ask them to see the counsellor to discuss the implications of all these things. And also if we have any concerns, we always discuss in our group meeting, so that we make sure that we are not doing anything that isn't ethically correct." [Doctor Rana, The Fertility Centre]

"I think that's where counselling comes in useful. Someone who wanted a different ethnicity, we'd probably have to advise them against it, or tell them they'd have to think about it. If they were really insisting we'd have to tell them to go to our ethics committee" [Doctor Ali, Creative Fertility]

Interestingly, without being prompted, all clinicians drew on the acceptability of single white women selecting a BME sperm donor (to conceive using their own eggs). This example highlighted the stratification of women's reproduction through egg donation compared with the aforementioned group of single women using sperm donation. In the commercialised context of sperm donation, recipients typically select their own donor from a catalogue of sperm donors. In this context, clinicians conceptualised their own intervention in restricting white women's access to BME sperm donors as 'racial discrimination'.

Although clinicians saw single white women's preference for a BME sperm donor as embodying a consumer motivation, they conceptualised these women as exotifying, rather than improving, their child's characteristics (which appeared to be more acceptable). Thus in this context, women's donor selection practices and the crossing of racialised reproductive boundaries were framed as a matter of individual and consumer choice, rather than as an ethical concern. This view is illustrated by the quote below from Mrs Redwood:

"If it is a single woman, using a sperm donor, you know, all the fantasies are up in the air. You would be amazed by the number of single women who want a different race donor to themselves. They choose a donor sperm with, I don't know, Indian, African [laughs] because they find it exotic" [Mrs. Redwood, Interview, Creative Fertility]

As illustrated above, clinicians actively shaped the preferences for donor characteristics that recipients of egg donation could request within the clinics according to their own expectations of the recipient role. Their discourses revealed a range of nuanced contradictions which were shaped by wider ideals of 'race', kinship, gender and the market. Clinicians' expectations of the recipient role also shaped how clinicians categorised recipients as 'good' recipients and as 'demanding', or rather 'anxious', recipients, and the repercussions of this for recipient agency.

5.4 Classification of Recipients: The Good as Deserving and the Demanding as Anxious

According to Clarke et al., (2010: 83), stratified (bio)medicalisation can occur when clinicians classify patients as 'good'/'deserving' or 'bad'/'undeserving' by virtue of their "compliance". Studies which have explored clinicians' classification of

individuals as ‘suitable’ or ‘unsuitable’ patients have predominantly focused on the impact of clinicians’ labelling of patients on patients’ access to fertility treatment (Doyal, 1987; Haimes, 1992; Pennings, 2001; Price, 1997; Steinberg, 1997; Roberts, 1999, Malin, 2003; McCormack, 2005; Bergmann, 2015). In this study, clinicians labelled recipients as ‘good’ or ‘demanding’ based on recipients’ behaviour in the matching process. Interestingly however, one strategy (amongst others) used by clinicians to deal with ‘very demanding’ recipients who challenged their authority was to re-frame them as being ‘very anxious’ recipients, as will be explored below.

Clinicians labelled recipients who met their expectations of the recipient role in positive terms such as “good” “lovely” and “deserving”. These ‘good’ recipients exercised passive and minimal agency in the matching process and accepted clinicians’ decision-making without question or challenge. Clinicians saw compliant recipients as women who were willing to compromise on their ideal preferences for donor characteristics, who were content with the information provided to them about their donor and who accepted the first donor that was allocated to them (regardless of whether their ideal preferences were met). Clinicians saw recipients’ compliant behaviour as reflective of their trust in clinicians to make decisions on their behalf and as having ‘come to terms with’ their own infertility and using donor eggs, as illustrated by the quotes below from nurses at each clinic:

“I think it comes down to their whole comfort level with having egg donation. I think people who are really comfortable with it are generally less anxious about someone being an absolute perfect physical match. They just don’t mind. Who just want to have a child and are very comfortable with the fact that this is not their egg, so it doesn’t matter to them” [Anna, Nurse, Creative Fertility]

“I think at the end of the day, maybe those people who said that they don’t mind what the ethnicity is, they don’t mind whatever, what anything is, at the end of the day they know what they want, and they want a child. And they are trusting us to give them that child” [Noreen, The Fertility Centre]

As illustrated by the quotes above, clinicians conceptualised ‘good’ recipients as having accepted using donor eggs, and the limits of their own infertility, and so were not intent on achieving the ‘exact’ physical resemblance with their child. They were seen as trusting clinicians to choose a donor on their behalf, and indeed, as trusting clinicians’ medical diagnosis of infertility and its solution (egg donation).

On the other hand, clinicians’ labelled recipients as non-compliant, or more specifically as “demanding” and “difficult”, when they exercised too much agency. As illustrated in the sub-section above, clinicians pathologised recipients who exerted too much choice or did not make the right kind of choices. Clinicians also labelled recipients as ‘demanding’ or ‘difficult’ when they behaved in ways which disrupted other expectations that clinicians had about the recipient role, such as recipients who regularly contacted the clinic for ‘no reason’, recipients who challenged clinicians’ authority by questioning or refusing to comply with their advice or with scheduled clinic appointments and recipients who were overtly emotionally distressed (e.g. crying).

In relation to matching, clinicians’ labelled recipients as ‘demanding’ or ‘difficult’ when they had lots of specific preferences for donor characteristics, were not willing to compromise on their preferences for resemblance, specifically requested a donor of a different ‘race’ to themselves, or asked lots of questions about the donors they were offered (particularly at Creative Fertility). Despite stressing that it was recipients’ “prerogative” to decline donors, the most common behaviour that clinicians attributed to ‘demanding’ recipients was the declining of multiple donors. Clinicians reasoned that these recipients were “obsessed” with having a donor who was an “absolute physical match” with their own characteristics because they were “stuck” on wanting

a child who physically resembled themselves and concluded that this was because these recipients had not accepted the lack of physical resemblance that was associated with not having a genetic connection with their child.

Clinicians held such a medicalised view of female infertility they reasoned that ‘demanding’ recipients had not psychologically come to terms with using donor eggs (the medical solution) and were ultimately in denial about their own infertility (the medical diagnosis), the two being synonymous in these fertility clinicians’ view. The quotes below from Anna and Noreen reflect clinicians’ view of recipients who exerted too much agency in the matching process:

“The other ones who are more ridged in the matching process, I think they’re still in denial that they can’t use their own eggs. They still want to use their own eggs, and this is like their control” [Noreen, The Fertility Centre]

“I think people that are still trying to hang onto the idea that this is their genetic child, or that they want this child to physically resemble them as much as possible, are going to be more strict and not willing to compromise [...] The most difficult recipients are the one that are very very caught up on all physical aspects of the donor, and are just stuck on their criteria. They want it to be them, and we can’t give them enough reassurance I guess, ‘cause they’re having to just take our word on this. Some people get to the point where they can barely accept anybody because they just grill you about every aspect of this person’s appearance” [Anna, Creative Fertility]

During observations of matching sessions, nurses often reflected that some recipients were being ‘difficult’ and declined multiple donors because they were ambivalent about using donors eggs and wanted to actively delay having their treatment. This view is illustrated by the excerpt below from ethnographic observations of a matching session at Creative Fertility:

“The nurses were not fond of this next recipient who showed up on the waiting list. Jemma said that she was being difficult. When I asked why, Jemma said that she was being difficult because she kept declining donors that she was matched with. Jemma said it is because she doesn’t really want to use a

donor's eggs but is going ahead anyway". [Field notes, Day 31, Creative Fertility]

Clinicians reasoned that recipients who declined multiple donors sought to retain a degree of control over their own reproduction or were declining donors as a way of delaying their own treatment because they were reluctant to use donor eggs. Thus, according to clinicians, recipients' declining of donors was neither a reflection of clinicians' decision making nor of the characteristics possessed by donors. Instead, they saw recipients' declining of donors as stemming from recipients' own 'unresolved underlying issues' in using donor eggs, and ultimately in accepting their own infertility. For clinicians, there was therefore very little they could do to help these recipients in the matching process. These recipients were seen as not trusting clinicians' authority and decision-making (in matching and more generally) and therefore challenged clinicians' deep-seated role as medical gatekeepers.

Recipients who consistently declined multiple donors also disrupted the matching process more generally and the financial running of the clinic, both of which relied on recipients' acceptance of donors. In order to manage such disrupts and threats, clinicians re-framed recipients' agency in declining donors from being an active and autonomous decision to being symptomatic of a pathological denial about their own infertility and their 'medical need' to use donor eggs. In this respect, clinicians re-conceptualised 'demanding recipients' (who were a threat to clinicians' authority) as being 'very anxious recipients' with underlying issues (who were not a threat to clinicians' authority), as illustrated by the quote below from Mrs. Redwood:

"People who still have issues and haven't completely come to terms with the fact that they do need egg donation generally raise objections at the time that they are matched. This is going to happen. It hits them in the face, and suddenly there are all sorts of objections that have nothing to do with the donors' characteristics [...] I think it's more the anxiety of having a child that is different, and having a child who has genes that you can't understand or

control, rather than being a highly demanding patient. The very highly demanding patients generally are the most anxious ones” [Mrs. Redwood, Creative Fertility]

Clinicians thus neutralised the threat of recipients’ behaviour to their own authority and re-framed it as an issue that lay with recipients themselves. Thus, whilst clinicians saw it as acceptable for recipients to exhibit some agency in the clinical context of egg donation, it was not seen as acceptable for recipients to display ‘too much’ agency or anxiety, i.e. outside of clinicians’ expectation of the recipient role. At Creative Fertility, all of the clinicians who were interviewed spoke about an informal clinic policy whereby recipients who declined three or more donors would be referred to counselling. This ‘policy’ was also relayed to recipients during their Initial Consultation with the clinic. Clinicians were concerned that recipients who were ‘not coping’ with egg donation or had underlying issues required intervention on the grounds that they: might regret going through egg donation, might reject their child in the future, would be likely to pull out of treatment or would be unable to accept a donor.

Clinicians thus saw it as their role to intervene in the treatment of these recipients, in the form of counselling, to help them “unknot” their underlying issues and to help them to proceed with treatment, i.e. to accept a donor. Thus counselling for recipients was conceptualised by clinicians as a disciplinary tool, rather than as a ‘therapeutic’ tool (as recommended by the HFEA), to dissuade recipients from persistently declining donors and ‘fix’ their non-compliant behaviour. Recipients who were labelled as being ‘too anxious’ by clinicians were given little choice about being referred to counselling. The quotes below from Jemma and Mrs. Redwood illustrate clinicians’ conceptualisation of recipients’ refusal of donors being symptomatic of

recipients' underlying psychological issues and their subsequent need for counselling and compliance:

“If I’m concerned, or I feel they’re not coping with the whole situation, because that’s when you’ll pick it up, because they’re not coping with it. They’re matched, and they’re declining, declining, even though they’re good donors, so there’s obviously some sort of problem there. So yeah, it’ll come up then, and that’s when you’ll push for the counselling” [Jemma, Nurse]

“Other recipients will decline 1, 2, 3, by which time I will have said to my coordinating nurses, ‘Could you please send this lady to see the counsellor so that the counsellor helps us pinpoint exactly what their expectations are, because obviously we’ve had three donors turned down that matched what we had recorded as acceptable, and there must be another issue that needs to be discussed [...] When we feel that someone is particularly anxious, or highly strung, or just, is objectionable to any step, then generally we recommend, we insist, that they see a counsellor, to sort of help unknot all the issues and prepare for a smooth treatment”. [Mrs. Redwood, Director]

However, this policy was not seen being put into practice. For example, numerous recipients declined more than 3 donors (as will be explored in Chapter 8) and were not referred to counselling. This ‘3 strikes rule’ then appeared to be more a looming threat in the matching process. However, this threat was put into action during earlier stages of the egg donation process when doctors encountered recipients that they found difficult to manage. For example, during observations clinicians referred several recipients to counselling before proceeding with treatment because they displayed overt signs of (uncontrollable) emotional distress.

5.5 Conclusion

This chapter showed how clinicians categorised patients' characteristics and recipients' preferences and behaviour in inherently racialised and medicalised ways. When classifying the ‘ethnicity’, physical and social characteristics of donors and

recipients, clinicians negotiated pre-existing categories and ascribed patients to these categories based on their own perception of skin tone.

The recorded outcome of these categories was shown to be highly subjective and socially constructed process, based on a variety of influencing factors, such as: clinicians' perceptions of patients, patients' perceptions of themselves, how clinicians posed questions to patients, how patients responded and the responses that were recorded by clinicians. Clinicians' ascribed patients to an 'ethnic' category based on their own perceptions of patients' skin tone and literally 'marked' the 'ethnicity' of some white patients by recording additional information about their skin tone, nationality, geographical ancestry or place of birth. This process of ascription was more laboured for donors than for recipients, for whom clinicians sought to discern their 'natural' and genetically inheritable skin tone.

Clinicians held multiple expectations of the type of agency that recipients should exercise in the clinic and shaped recipients' preferences accordingly. Whilst they expected recipients to want resemblance with their donor they also expected recipients to be willing to compromise on this preference and accept difference in their donor. However, clinicians did not see it as equally acceptable for recipients to specifically request difference, particularly in relation to 'race'. Nor did they see all types of differences as equally acceptable.

Clinicians' conceptualisations of BME recipients and white recipients wanting a donor of a different 'race' also revealed nuanced differences in the motivation they attributed to these groups of recipients and their subsequent willingness to meet their preferences. Whereas clinicians saw it as acceptable, and even necessary, for BME recipients to request a white donor they did not see it as equally acceptable for a white recipient to request a BME donor. Conversely, clinicians saw it as altogether

unacceptable for white recipients to request a BME egg donor. Echoing HFEA policy legacy, clinicians framed recipients' specific request for 'racial difference' as consumerist, going against the welfare of the child and needing to be circumvented.

The example of single white women requesting a BME sperm donor also highlighted how clinicians' views were specific to female recipients of donor eggs, illustrating how racialised conceptualisations of gender, reproduction and kinship also shaped clinicians thinking. Clinicians' discourses around the permissibility of married BME women requesting a *white egg donor* and single white women requesting a *BME sperm donor* also revealed how 'geographies of desirability' (Nahman, 2006) shaped clinicians' perspectives. Here, the former group of women were seen as wanting to 'improve' the characteristics of their child whilst the latter group of women were seen as 'exotifying' the characteristics of their child.

Clinicians' expectations of recipient agency also shaped their implicit categorisation of donors and recipients. Recipients who were compliant with clinicians' expectations were conceptualised by clinicians as 'good' recipients who had come to terms with their own infertility and using egg donation whilst recipients who were not compliant, e.g. recipients with lots of preferences or recipients who declined multiple donors, were seen as 'demanding'. 'Demanding' recipients were a threat to clinicians' authority, which clinicians contained through their re-conceptualisation of 'demanding' recipients (consumers) as inherently 'anxious' recipients (patients). As such, clinicians reasoned that it was their role to intervene in and manage the anxiety of these recipients by referring them to counselling. Counselling was used by clinicians as a tool to manage recipients who displayed 'too much' agency and who challenged clinicians' expectations of the recipient role and 'racialised reproduction'.

This section has shown how clinicians' classification of donors and recipients into formal and implicit categories was an inherently medicalised and racialised process of stratification. In the following chapter, the ways in which clinicians allocated donors to recipients based on these categories will be explored.

Chapter 6: Clinicians' Allocation of Donors to Recipients

6.1 Introduction

In the previous chapter, we saw how clinicians' classified patients' characteristics, shaped recipients' preferences for donor characteristics and re-interpreted the behaviour of 'demanding' recipients as being inherently 'anxious' and requiring intervention. In this chapter, clinicians' discourses and practices of allocating donors to recipients based on their ascribed characteristics and the ways in which clinicians prioritised competing matching criteria, will be explored. At the time of fieldwork, there was no policy regulating clinicians' practices of donor-recipient matching. Therefore, donor allocation was left entirely to the discretion of clinicians and clinic management (e.g. through policies).

Despite the differences in the organisation of matching between each clinic clinicians across both clinics saw matching as having similar aims. These included the need to ration egg donors because of a shortage of donors and clinicians' mandatory requirement to take into account the welfare of the child, which they intertwined with their role in matching. Clinicians' discourses and practices of matching revealed that clinicians had organised donor allocation around what might be termed 'primary matching criteria', comprising "medical" characteristics and "race"/ethnicity, and 'secondary matching criteria', comprising the waiting list, recipients' preferences and general physical characteristics. Clinicians did not overtly make this distinction themselves, but it provides a useful categorisation to understand their prioritisation and negotiation of matching criteria.

Below, clinicians' prioritisation and negotiations of 'second matching criteria', followed by 'medical criteria' and 'race' will be explored. The final section of this chapter will explore the ways in which clinicians' informal classifications of recipients as 'demanding' shaped their practices of matching.

6.2 Secondary Matching Criteria

In the context of a shortage of donors, clinicians at both clinics saw a central aim of matching as being to "ration" the allocation of donors in a "fair" and equitable way. The waiting list for donors was a central mechanism to this aspect of donor allocation, which was seen by clinicians as ensuring this process was fair.

Some work has been undertaken on the role of waiting lists in resource allocation in areas of public health care (Pope, 1991; Doyle and Bull, 2000; Foote et al., 2002) in organ donation (Schmidt, 1998; Sung, 2005), and in the field of ARTs (Stacey, 1992; Steinberg, 1997; Malin, 2003). However, few scholars in ARTs have paid attention to the distinction between recipients' access to the clinic and their access to resources within the clinic, such as through the clinic waiting list for donors (Millns, 1995; Price, 1997; Pennings, 2001). As noted by Pennings (2001), how clinicians rank recipients on the waiting list for egg donors and their selection of recipients from the waiting list (rather than admission to) has received hardly any attention. Transnational studies which have explored clinicians' allocation of egg donors to recipients rarely mention the role of the waiting list in clinicians' decision-making (Nahman, 2006; Whitakker and Speier, 2010; Bergmann, 2011; 2015; Kroløkke, 2014).

The waiting list involves a 2 step process (Pennings, 2001), including admission to the waiting list (and treatment) and ranking of those on the waiting list (which has received less attention). Pennings (2001; 2005) suggests a "points system" based

allocation system, where clinicians allocate donors to recipients based on 4 primary criteria: waiting time, medical urgency, phenotype matching and synchronisation, although his suggestions were more theoretically than empirically informed. As yet, no previous empirical studies have explored clinicians' negotiation of the waiting list for donors in the context of egg donation in the UK.

Clinicians framed the allocation of donors to recipients in a moral way, in which one's place on the waiting list was the main determinant of one's access to donors (and treatment). Thus clinicians were keen to stress the 'fairness' of the waiting list (Pope et al., 1991; Pennings, 2000) and its "simple" and "mechanical" nature, whereby the next available donor would be allocated to the recipient at the top of the waiting list, who had been waiting the longest. The quote below from Mrs. Redwood, the Director at The Fertility Centre, illustrates this view:

"The matching process is quite fair, as soon as one donor comes up with so many characteristics, there is this patient, 1, 2, 3, 4, 5, that match in order of waiting. So we would offer to the first patient, and if declined to the second one, and if declined to the third, and so on" [Mrs Redwood, Creative Fertility]

The waiting list was referred to as a necessary mechanism for managing donor allocation at both clinics, although it was more a central feature of donor allocation at Creative Fertility than at The Fertility Centre. This was primarily due to the larger number of donors and recipients at the clinic, the long waiting times to be matched and the electronic formalisation of the waiting list.

The list for donors was not determined by ability to pay (although this was a prerequisite of joining the waiting list) nor by urgency/need (e.g. age or infertility history). Instead, the waiting list was ordered by time spent waiting (as mentioned) and by recipients' preferences for donor characteristics, so that recipients who were

willing to accept donors with particular characteristics would show up on the waiting list for those donors and not for others.

According to clinicians, recipient choice was another organising criterion of matching. Clinicians described the aim of matching, and their own role in matching, as being to meet recipients' preferences for donor characteristics and to ensure that recipients were "happy" with the donor that they were matched with, and so would accept her. This view is illustrated by the quotes below from nurses at each clinic:

"I think an ideal match is something that the recipient is absolutely thrilled with." [Anna, Creative Fertility]

"A good match I would say is a 90% match, based on the preferences form that we have. It's subject to the recipient. What's important to them will be important for me when I match." [Noreen, The Fertility Centre]

As discussed in the previous chapter, clinicians had expectations about the type of preferences that recipients could state in the clinic. One such expectation was that recipients would want a donor who matched their own physical characteristics. When asked about the characteristics by which they matched donors and recipients by, it was common for clinicians to respond with a list of physical characteristics which were recorded by clinicians (and outlined in the previous chapter), as illustrated by the quote below:

PD: *"Which characteristics do you have in mind when matching?"*

Anna: *"So, eye and hair colour, height and weight, and sort of general skin colouring are the main ones"* [Anna, Creative Fertility]

However, in practice, the waiting list, recipients' preferences and physical characteristics shaped, but did not determine, the allocation of donors to recipients at

both clinics. It was common, for example, for clinicians to allocate a donor to a recipient who was more than halfway down the waiting list, with different physical characteristics, and/or to override recipients stated preferences for donor characteristics. That is, clinicians allocated donors to recipients based on their own perceptions of what constituted an “appropriate” or “good” match, as illustrated by the quotes below from Jemma and Doctor Rana at each clinic:

“But we try and make it fair, so we do try and offer in order of who is on the list first, And we basically just compare their physical profiles. Often, a difficult one is when there’s no-one’s at the top half of the list who maybe is as physically appropriate, whereas someone who just joined the list might be [Jemma, Creative Fertility]

“So I called Noreen, and I said ‘look, we got a Muslim donor, who is top of the list amongst those 4 recipients?’. Because it’s small clinic, we can just do it. Because patients get better service you see, the appropriate donor. So, 4 patients on the waiting list, I’ll say no. 1, and Noreen will say ‘no no no doctor, she looks very much like number 3, that is a better match. So I say ‘yes, okay, we’ll give it to number 3’” [Doctor Rana, The Fertility Centre]

Therefore, clinicians did not see all types of matches as equally acceptable. In seeking to make an “appropriate match” clinicians inherently sought to avoid making an inappropriate or “unsuitable” match. Currently, there is no specific policy prescribing clinicians’ matching practices. However, at both clinics, clinicians saw a primary aim of their role in matching as being to protect the welfare of children born through the clinic, as will be explored below. Clinicians thus intertwined their role in matching with their mandatory duty to take into account the ‘welfare of the child’. Thus the waiting list, recipients’ preferences and matching physical characteristics were all secondary to the clinics’ own imposed primary matching criteria of ‘medical characteristics’ and ‘ethnicity’, both of which were legitimised as being in the best interest of children born through egg donation. These will now be explored in turn below.

6.3 ‘Medical Matching’

In seeking to fulfil their duty in protecting the ‘medical welfare of the child’, clinicians cited internal policy which imposed “*medical*” matching criteria intended to reproduce ‘healthy’ children and ensure a ‘medically safe’ pregnancy and birth. There is little in the social sciences or medical literature on matching donors and recipients according to medical criteria. In the past, the HFEA stipulated that clinicians matching donors and recipients by Cytomegalovirus (CMV) status, although this was removed due to a lack of evidence about CMV transmission in egg donation (as explored in Chapter 4).

Although both clinics medicalised matching and reproduction through their definition of some characteristics as a ‘medical risk’ each clinic did so by prioritising different ‘medical’ matching criteria, thus illuminating the socially constructed nature of these medicalised criteria. The ways in which medical criteria were prioritised in each of the clinics will now be explored in turn.

Creative Fertility

At Creative Fertility, clinicians said that they prioritised the height and weight (BMI) of donors and recipients when matching. Clinicians’ discourses revealed that they conceptualised these characteristics as a ‘medical risk’ in matching which required medical intervention to ensure ‘medical (physical) safety’ of children born through egg donation and recipients. In particular, clinicians drew on the potential danger of matching a large donor with a smaller recipient on the basis that this might lead to a recipient gestating a baby that was too big for her to give birth to. According to this reasoning, the access of recipients who were considered to be ‘small’ would be

restricted to small donors whereas ‘large’ recipients could supposedly be matched with any size donor. This view is illustrated by the quote below from Anna:

“The height and weight will be a difficult one sometimes. Because, physically speaking, if there’s a very small recipient, who’s got the same hair and eye colour, but it’s a very large donor, you shouldn’t, for the medical safety of pregnancy and things like that, we probably shouldn’t be offering someone like that. So BMI tends to be a big deciding factor” [Anna, Creative Fertility]

As illustrated by the quote above, clinicians prioritised medical criteria (height/weight) over and above the matching of physical characteristics (hair colour and eye colour). In medicalising height and weight as a risk, clinicians appeared to be drawing on a naturalistic assumption about women’s bodies regulating the size of their babies in natural reproduction. Thus, clinicians seemed to conceptualise their own role in regulating the height and weight donors and recipients as mimicking nature and natural reproduction, which they saw as adhering to their duty to protect the medical welfare of recipients and donor-conceived babies. Elsewhere, it also was not uncommon to hear doctors tell recipients that IVF was so successful because doctors had been perfecting the ability to “mimic nature”.

At The Fertility Centre, clinicians did not report prioritising height and weight when matching. Instead, when questioned, they explicitly discounted height and weight as being a primary or medical matching concern. Instead, clinicians drew on the imposition of different ‘medical’ matching criteria, as will be shown below.

The Fertility Centre

At The Fertility Centre, clinicians prioritised the Cytomegalovirus (CMV) status of donors and recipients as the primary criterion of matching. The role of CMV

matching in egg donation was discussed in Chapter 4, where it was shown that the HFEA removed policy on CMV matching in egg donation due to lack of medical evidence. However, the Director of The Fertility Centre, who championed this internal clinic policy, was unaware of the removal of CMV matching from the HFEA Code of Practice in 2007 and drew on this policy and welfare of the child concerns to justify this practice, i.e. to prevent a child being born symptomatic at birth due to contracting congenital CMV.

Therefore, the CMV status of donors and recipients was medicalised by the clinic as a ‘medical risk’ in matching and as needing intervention and management by medical professionals. This medicalisation was specific to recipients of egg donation; couples undergoing fertility treatment using their own gametes or a known egg donor were not subject to such stipulations. In this respect, clinicians appeared to try to ‘improve on nature’ (rather than ‘mimic’ nature). As illustrated by the quote below, clinicians prioritised matching donors and recipients by CMV status, over and above matching for resemblance or physical characteristics:

“What I’m saying is, how you will match first. First step is, if a recipient is CMV negative, then the nurse and myself will say ‘Oh, we have to find a CMV negative donor for her’. So, we can’t offer her the donors who are CMV positive, even if they had blue eyes like they wanted. So, the first criteria is CMV. If somebody is CMV positive, it’s not a problem, they can have positive donor or negative it makes no difference. So that is the first thing. And then, once we get CMV sorted, then we go for blue eyes and other physical characteristics” [Doctor Rana, The Fertility Centre].

As illustrated by the quote above, CMV negative recipients could only be matched with CMV negative donors whereas CMV positive recipients could be matched with CMV positive and CMV negative donors (as these recipients had already contracted the virus). Despite the emphasis on CMV matching, Noreen, the nurse who was required to implement this practice, saw it as “confusing” and “unfair”. For example,

whenever I asked Noreen to explain the rationale for CMV matching in egg donation she either avoided the conversation or directly asked for the topic to be changed. Acknowledging the prevalence of the CMV virus in the general population, Noreen described CMV as akin to the “common cold”. Noreen’s particular concern was the impact of CMV matching on CMV negative recipients, who had to wait longer to be matched with a donor, as illustrated by the quote below:

“The only thing that I found difficult in the matching process is the matching with CMV. If we do not match the CMV then we won’t have any waiting list. CMV positive donors can only be matched to CMV positive recipients, but CMV negative donors are very rare.” [Noreen, The Fertility Centre]

However, Noreen also cited the need to manage the risk of congenital CMV for donor-conceived children, the nature of which went far beyond the common cold. Thus, despite being unsure about CMV matching, and at times questioning it, Noreen continued to implement it at the behest of Doctor Rana. Given the ‘rarity’ of CMV negative donors, these donors were often more valued by clinicians, who sought to ‘save’ them for CMV negative recipients.

Creative Fertility on the other hand stopped matching by CMV status after the removal of this HFEA policy in 2007. The Director of the clinic also saw CMV matching as severely restricting recipients’ ability to access donors and the clinic’s ability to match donors and recipients, and so applauded the HFEA’s change in policy, which she had been vocal in criticising for lacking in evidence base, as illustrated by the quote below:

“I’ve stood up and said this story of CMV has to stop. You are penalising all the poor recipients who have never been exposed to CMV and that’s not fair [...] I’ve had ladies wait 1 year because of their CMV. Oh, there was this perfect donor for her, but unfortunately she was CMV negative and the donor was positive. It was not medically founded. Finally somebody heard, and finally somebody scrapped it from the regulation.” [Mrs Redwood, Creative Fertility]

The aim of the above internal medicalised matching criteria at each clinic was to reproduce ‘healthy children’, an outcome which was valued and encouraged. This aim was prioritised over secondary matching criteria such as meeting recipients’ preferences for donor characteristics or achieving physical resemblance between recipients and their child. Having explored clinicians’ discourses of allocating donors to recipients according to medicalised criteria, attention will now be paid to clinicians’ practices of matching donors and recipients according to these criteria. The ways in which clinicians foregrounded and minimised the importance of these criteria, and how they ‘strategically naturalised’ (Thompson, 2005) these criteria to make matches, will also be explored.

6.3.1 Clinicians’ Negotiation of Medical Criteria

Height and Weight

Given the lack of information in existing literature about matching egg donors and recipients by height and weight, it is difficult to contextualise the actual height and weight differences matched by clinicians. Therefore, clinicians’ discourses and practices will be triangulated to uncover patterns in clinicians’ practices of matching donors and recipients by these characteristics. As will be shown below, despite clinicians’ emphasis on closely matching height and weight at Creative Fertility, descriptive analysis of 152 matches over the period of observations at the clinic (10 months) revealed that clinicians matched donors and recipients across a wide range of height and weight differences and that this was done.

Of the 152 matches for which information was collated, the height of matched donors and/or recipients was missing in 19 cases and the weight was missing in 22 cases (i.e. they were missing because they had not been formally recorded by clinicians).

Sometimes clinicians matched donors and recipients even when this information was missing. In such cases, clinicians commonly relied on their own perceptions of donors and recipients height/weight. Of the 133 cases for which the weight of donors and recipients was recorded, the average weight difference between matched donors and recipients was 8kg and the largest weight difference was 30kg. Of the 130 cases for which the height of donors and recipients was recorded, the average height difference between matched donors and recipients was 6cm and the largest height difference matched was 19cm.

These differences were slightly smaller than at The Fertility Centre but were not significantly difference. At The Fertility Centre, descriptive analysis of 40 matches showed the average matched weight difference was 13kg and analysis of 44 matches showed the average matched height difference was 7cm. The table below summarises height and weight disparities between matched donors and recipients at each clinic.

Table 6.1 Height and Weight Differences between Matched Donors and Recipients at Both Clinics over Period of Observations

	Weight Difference (kg)		Height Difference (cm)	
	Creative Fertility	The Fertility Centre	Creative Fertility	The Fertility Centre
Average	8	13	6	7
Median	6	11	5	5
Mode	6	2	5	4
Max	30	35	19	25
Cases	133	40	130	44
Missing	19	25	22	21
Total	152	65	152	65

Although clinicians at Creative Fertility sought to prohibit the allocation of ‘large’ donors to ‘smaller’ recipients, analysis of their matching practices revealed that in the majority of cases recipients were actually shorter and weighed less than the donors they were allocated. Table 6.2 below outlines the distribution of height and weight differences between matched donors and recipients at Creative Fertility.

Table 6.2 Distribution of Height and Weight Differences between Matched Donors and Recipients at Creative Fertility

Creative Fertility	Number of Cases (Matches)	
	Weight	Height
Donor Bigger than Recipient	83	70
Donor Smaller than Recipient	44	51
Donor and Recipient Same	6	9
Total Number of Cases	133	130

As illustrated by the above Table, recipients weighed less than the donors they were matched with in 83 cases and weighed less in 44 cases at Creative Fertility and recipients were shorter than the donors they were matched with in 70 cases and taller in 51 cases. Thus contrary to clinicians’ discourses about not matching a ‘bigger donor’ with a ‘smaller recipient’ their practices revealed that they did this in the majority of matches that they made.

During observations of matching sessions at Creative Fertility it wasn’t uncommon for clinicians to draw on height and weight differences as a risk to kinship resemblance, rather than as a medical risk. For example, clinicians raised concerns about matching a small recipient with a large donor for resemblance. Furthermore, in

cases where recipients were using a gestational surrogate, in addition to an egg donor, clinicians typically matched the height/weight of donors to recipients and not to the surrogate who would be giving birth to the child.

CMV

At The Fertility Centre, the CMV status was recorded for 40 matched donors and recipients. Below, Table 6.3 outlines the number of matches made at The Fertility Centre according to CMV status.

Table 6.3 CMV status of Matched Donors and Recipients at The Fertility Centre

Recipient CMV Status	Donor CMV Status	Number of Matches
Positive	Positive	21
Positive	Negative	3
Negative	Negative	12
Negative	Positive	4
Total number of Cases		40

As illustrated in the table above, unlike at Creative Fertility, clinicians' practices echoed their discourses of matching donors and recipients according to 'medical characteristics' at The Fertility Centre. A CMV positive donor was allocated to a CMV negative recipient in 4 cases, something which clinicians were adamant they would not do. Furthermore, a CMV negative donor was allocated to a CMV positive recipient in 3 cases, which was technically permissible, but something which clinicians generally avoided (as this would reduce the already limited availability of donors for CMV negative recipients).

At both clinics, the largest discrepancies in clinicians' practices of matching by 'medical criteria' were in relation to the matching of BME recipients, as will be explored below.

BME Recipients: Stratifications of (Bio)Medicalisation

As illustrated above, clinicians saw 'medical criteria' determining which donors and recipients could be matched. However, clinicians did not use these criteria as equally applying to all types of matches and recipients. As illustrated in the section immediately above, clinicians' practices revealed that they did not always adhere to their primary aims of matching according to medical criteria. In particular, the 'exception to the rule' (medical criteria was not imposed) was when clinicians were matching BME recipients and BME donors. This exception brings to the fore the other primary matching criterion imposed by clinicians at both clinics, i.e. 'ethnicity' (which will be discussed in more detail in the following sub-section).

At Creative Fertility, where clinicians saw matching the height/weight of donors and recipients as a priority, the small number of matches made between BME recipients and BME donors (n=9) had missing information in the majority of cases (n=7). Furthermore, the minority of cases for which this information were amongst the largest height/weight differences in the whole sample of matched donors and recipients at the clinic (n=152). For example, in one case, a BME donor was 25kg and 18cm bigger than the BME recipient she was matched with. At The Fertility Centre, where CMV status was prioritised as a primary matching criterion, the few cases where clinicians mismatched the CMV status of donors and recipients were when matching BME donors and recipients. Here, 6 out of the 7 cases where the CMV

status of donors and recipients did not match were between BME donors and BME recipients.

Clinicians' practices of matching by medical characteristics reflected their discourses of matching BME donors and recipients and their prioritisation of 'ethnicity' over medical criteria. The imposition of both medical criteria and ethnicity as primary matching criteria, coupled with a shortage of BME donors, meant that clinicians had to decide which of these matching criteria to prioritise in order to make a match. In such cases, clinicians prioritised matching the ethnicity of donors and recipients over their medical characteristics, thus racially stratifying medicalisation (Clarke et al., 2010). Clinicians rationalised their mitigation of medical matching criteria in these cases as being necessary, i.e. in order to prevent delays to BME recipients having treatment, and in some cases, to allow them to have treatment at all. The quotes below illustrate clinicians' prioritisation of ethnicity over medical criteria when matching BME recipients:

“Generally they [BME recipients] get a lot less, there's less donors to choose from, so there's not as much choice. Things like BMI, we just need to offer regardless. But if we had somebody where the height and weight were going to be really ridiculously unmatched, well, we would probably ask and see what they thought.” [Anna, Creative Fertility]

“I mean before CMV, of course, is the ethnic thing [...] Especially if they're Afro-Caribbean and Asian recipients, it's difficult to find. And then CMV negative Asian donor, and Gujarati donor, and... forget all those things! So many ifs. It becomes difficult. So then in those cases, if the husband is CMV positive, then we say, then we explain to them, he is positive, anyway your embryo is going to be positive, as long as you don't mind, and if they accept, then we go ahead.” [Doctor Rana, The Fertility Centre].

As illustrated by the quote directly above, at The Fertility Centre rather than merely overriding CMV matching with ethnic matching, clinicians extended their clinical gaze to the CMV status of recipients' partners, and sought to match donors' CMV

with that of recipients' partners. Thus whilst BME recipients who were CMV negative were able to access CMV positive BME donors, their access to these BME donors was dependent on the CMV status of their partner. At both clinics, clinicians imposed medical matching criteria for white recipients and BME recipients in different ways.

Although the cases above illustrated how clinicians prioritised 'race' over 'medical matching criteria' specifically in relation to BME recipients, they also revealed clinicians' prioritisation of these matching criteria more generally. However, for white recipients, it was taken for granted by clinicians that both their medical characteristics *and* 'race' would be matched with donors. That is, 'race' was seen as one of multiple Master Statuses for white recipients, alongside their medicalised characteristics. For BME recipients on the other hand, 'race' was seen as an overriding Master Status (Hughes, 1945), i.e. as the dominant label by which they were matched and which overrode their medical characteristics.

Clinicians' perceptions and practices of matching donors and recipients by 'race' and ethnicity will be explored below. This will include exploring clinicians' discourses and practices of 'racial matching' and 'transracial matching'.

6.4 Racialised Matching: the Prioritisation of 'Race'

As illustrated in the section above, clinicians saw it as their responsibility to protect the medical welfare of the children born through egg donation. Clinicians also saw it as their duty to protect the 'social welfare' of children, which they also intertwined with their role in matching, and with the practice of 'racial matching'. The practice of 'racial matching', commonly referred to as 'ethnic matching', refers to the allocation of donors to recipients based on 'race', albeit under the guise of 'ethnic' categories.

The term ‘racial’ matching’ rather than ‘ethnic’ matching has been chosen to describe the practices of clinicians (as discussed in Chapter 2) as it most accurately reflected the subject of participants’ accounts. In recognising that ‘race’ does not in fact exist as a scientific construct ‘race’ and ‘racial’ terminology is kept in inverted commas.

As shown earlier, clinicians saw the aim of matching as being to facilitate physical resemblance between donors and recipients. This aim was intended to enable donor-conceived children to ‘pass’ as the offspring of their non-genetic parent, to conceal the use of donor gametes, in what scholars refer to as the ‘biomedical model’ of reproduction (Price, 1997; Braverman and Frith, 2014). This aim was based on the assumption that children would genetically inherit the physical characteristics of their donor and consequently share this ‘kinship resemblance’ with its mother (the recipient). Clinicians thus saw the purpose of matching donors and recipients for physical resemblance as a social welfare of the child concern, as illustrated in the quote below from Doctor Rana:

“So we try to find somebody who looks like the recipient. The idea, or the logic behind that being so the baby will be like them, so the baby will fit into their family, look like the others in the family, so that the child is not the odd one out. And then the welfare of the child is taken care of.” [Doctor Rana, The Fertility Centre]

Matching was therefore seen as a mechanism by clinicians to reproduce a normative ideology of the family in which the physical resemblance is seen as an expression of a genetic relationship (Ariza, 2015). Conversely, clinicians saw a lack of resemblance between recipients and their child, and therefore between recipients and donors, as a potential ‘risk’ to the welfare of the child, and as needing intervention by clinicians (Millns, 1995; Culley, 2005; Campbell, 2007). However, not all types of differences were regarded as a welfare of the child concern by clinicians, or as needing to be managed. That is, most physical differences between recipients and donors, i.e. eye

colour, hair colour and size, were not regarded as a social welfare of the child concern; they did see ‘racial resemblance’ and ‘racial difference’ as a threat to the welfare of the child and as needing intervention by clinicians.

Contrary to scientific understandings of ‘race’, which have discredited the notion of ‘race’ as a biological concept (Miles, 1989; Wade, 2015; Caballero and Aspinall, 2018), clinicians reified, reinforced and reproduced ‘race’ through their conceptualisation of “ethnicity” as a primary marker of differentiation and as a genetically inheritable physical characteristic (Roberts, 1999; Fogg-Davis, 2001; Szkupinski-Quiroga, 2007; Hudson, 2015; Deomampo, 2016). For example, clinicians commonly used ‘ethnicity’ as a proxy for skin tone, alongside racial terminology such as “Caucasian”, “Oriental” and “black”. That is, clinicians used ‘resemblance’ as a code for ‘race’ (Ariza, 2015; Deomampo, 2015; Hudson, 2015). As illustrated by the quote below from Anna, clinicians primarily conceptualised ‘ethnicity’ as a proxy for physical characteristics:

“Yeah, it [ethnicity] encompasses a lot of things I think, but generally, where they’re born, what country or where their parents were born, because obviously physical traits go along with that, like skin colour and things. So that’s really the main thing, it’s generally physical.” [Anna, Interview]

All of the clinicians in this study described “ethnic matching” as a “standard” and “established” practice within their clinics. Few clinicians cited HFEA policy on ‘ethnic matching’, although all clinicians drew on ‘ethnic matching’ as an ethical, moral and welfare of the child concern. Echoing past HFEA policy, clinicians defined the welfare of the child as best being met by a normative model of the family, in which children racially resemble their parents. Clinicians thus singled out ‘race’ as the single most important marker of normative racialised family boundaries and as “a key medium for the transmission (or display) of kinship” (Wade, 2007: 8). As such, ‘racial

matching' was seen by clinicians as a primary mechanism for constructing 'kinship resemblance' between recipients and their child and as protecting the welfare of the child.

Clinicians therefore saw the aim of matching, and their role in matching, as being to reproduce 'racial resemblance' between donors and recipients and a racialised ideology of the family, which they legitimised as being in the best interests of the child. That is, clinicians sought to reproduce "race-kinship congruity" (Wade, 2012: 79), i.e. the idea that "people who are related by consanguineous kinship should also have a 'racial' appearance that is congruent with— explicable in terms of — their kinship connections" (ibid). Most clinicians saw it as their responsibility to ensure this on the grounds that they were 'helping' to create a child and had some control over donor-conceived children's well-being, as illustrated by the quote below from Noreen:

"I think we're thinking of the welfare of the child here, the resulting child. If you can have the control, you know, preventing the child to be bullied. So for example, if the child turned out to be Caucasian and the birth parents are Indian, there might be a bit of confusion for the child as well. So, first and foremost welfare of the child is the reason why we match ethnicity". [Noreen, The Fertility Centre]

Several clinicians also described the aim of 'racial matching' as being to protect recipients by concealing the use of donor gametes (Price, 1997). Clinicians highlighted the potentially stigmatising impact of using egg donation on recipients, and on their children. This included recipients and their children being marginalised within their wider community, "disinherited" by their immediate families and constantly having their legitimacy as a family questioned by others. As such, clinicians saw matching for resemblance as enabling recipients to maintain secrecy

about their use of donor eggs (and their infertility). This view is illustrated by the quote below from Mrs. Redwood:

“There’s all sorts of stigma about it [egg donation], so for some patients it’s very very difficult to talk about it. And we respect that, we can perfectly understand that in some families it’s going to be very difficult and in others it’s going to be more open. So that’s why we focused on the phenotypes” [Mrs. Redwood, Creative Fertility]

Some clinicians also referred to matching for resemblance as enabling recipients to maintain secrecy from their own child. A commonly held perception amongst clinicians in this study was that BME recipients were less likely than white recipients to be ‘open’ about egg donation with their child because of “cultural” reasons, a view that was reflective of some of the wider literature on disclosure (Culley and Hudson, 2006; Nuffield Council, 2013). For example, during observations of BME recipients’ consultations it wasn’t uncommon for clinicians to skirt over their mandatory requirement to encourage recipients to be open with their child. This view is illustrated in the quote below, from Doctor Demetrious, who had just finished explaining why it was “reasonable” for recipients to want a ‘racially matched’ donor:

“Which again is reasonable, because not all couples will tell the child, even if they say that they will now. Especially the ethnic minorities, I think that 80-90% of them will not tell the child, Caucasians a little bit more they will.” [Doctor Demetrious, Creative Fertility]

In conceptualising ‘race’ as a key mechanism for constructing kinship resemblance clinicians conversely pathologised ‘racial difference’ as an primary ‘kinship risk’. The concept of ‘kinship risk’ is introduced here to refer to physical differences between recipients and their child that might reveal the lack of a genetic relationship between recipients and their child, i.e. an imagined threat to the display of kinship resemblance. Clinicians saw it as risky to disrupt normative kinship boundaries and intertwined ‘natural’ (normative) racial hierarchies. They saw it as their responsibility

manage the crossing of racialised boundaries, with the ultimate aim of reproducing and reinforcing them. As such, clinicians sought to avoid reproducing ‘racially incongruent’ families (Wade, 2012) and rationalised their reproductive gatekeeping role as being in the best interests of the child (Steinberg, 1997; Culley, 2005; Szkupinski-Quiroga, 2007; Roberts, 1997; Malin, 2003, Campbell, 2007).

Here, clinicians typically depicted scenarios in which a lack of racial resemblance between recipients and their child would lead to children ‘suffering’, questioning their belonging within the family, having their belonging questioned by others and being “bullied” in the playground, as illustrated by the quote below from Doctor Rana:

“Well, we always believe in giving the person from the same ethnic origin. It’s so that the baby doesn’t suffer, for the welfare of the child. Because we don’t want anybody asking questions or pointing at the baby, so that when the child goes to the school, say the Indian couple will bring a white looking child, all the other children will make fun of the child and bully it. ‘How come you are so white, when your dad and mum are Asian? Everyone in school will ask, ‘who’s your dad, who’s your mum?’ The child will suffer. But if the child fits into the family, then there won’t be many questions. That’s the main purpose of matching by the physical characteristics.” [Doctor Rana, The Fertility Centre]

As illustrated by the quote above, clinicians commonly conflated ‘physical characteristics’, ‘race’ and ‘ethnicity’. The Directors of each clinic (in particular) recounted several ‘horror stories’ (Goode and Ben-Yehuda, 2010) to highlight the dangers of BME recipients using a white donor, and even a mixed ethnicity donor. Such stories were often used to legitimise the reproductive gatekeeping role of clinicians as being in the best interests of donor-conceived children and recipients. For example, in the quote below, Mrs. Redwood recounts a case of a black recipient with a white partner ‘insisting on’, and later regretting, having treatment with a mixed ethnicity egg donor:

“I remember another lady, she was Black, and she was really pushing for a donor who was mixed race, and her husband was Caucasian. And I said to her, ‘why do you want a mixed race donor and not a black donor? You’re going to have a mixed race baby anyway’. Anyway, she had the baby and the first thing she said to me was ‘ahh, this baby is so white’. You know, what can you say, ‘I told you so?’ You can’t give it back. So I think, people do not always have the right idea of what’s going to happen, or have misconceptions, but it’s really about thinking of the welfare of the child” [Mrs. Redwood, Creative Fertility]

On the whole, clinicians’ practices of racially matching donors and recipients reflected their discourses. That is, the majority of matches made at both clinics were between donors and recipients of the same recorded ethnicity. To reiterate, for the purposes of this study, a ‘racial match’ was defined as a match between donors and recipients from the same overarching ‘ethnic groups’ (i.e. white, South Asian, black African/Caribbean and Chinese) and a ‘transracial match’ was defined as the matching between donors and recipients from different overarching ‘ethnic groups’. At Creative Fertility, of the 152 matches observed at the clinic, 95% were between donors and recipients of the same ‘racial’ background and over 90% of the total matches made were between white donors and white recipients (n=142). At the Fertility Centre on the other hand, from the 65 matches recorded, 79% of donors and recipients were ‘racially’ matched, and the ‘ethnicity’ of donors and recipients was more diverse.

These figures need to be interpreted with caution however, for the reasons outlined in Chapter 3 and due to the subjective process of classification outlined in Chapter 5. To briefly recap some of the issues here, (a) the characteristics and categories used to record ‘ethnicity’ were limited, (b) clinicians relied on their own subjective perceptions of skin tone to record information, (c) some of the ethnic categories that donors and recipients were assigned to by clinicians were re-coded because they were haphazardly or sparingly used (e.g. ‘Sri Lankan’ was recoded to ‘South Asian’), (d)

inconsistent usage of lower-level ethnic categories made it necessary to use broad racialised categories (i.e. white, black, South Asian, Chinese) to present this data and (e) it is recognised that these broad ‘ethnic’ categories reflect ‘racial’ categorisation more than socio-political identity.

The category ‘white’, sometimes labelled and referred to as ‘Caucasian’ by clinicians, predominantly comprised white British patients, but included donors and recipients from a range of countries outside of the UK. The category ‘black African/Caribbean’, included donors and recipients who were labelled as black Caribbean and black African and the category ‘South Asian’ included recipients from Indian, Pakistani, Sri Lankan and Tamil ethnic backgrounds. As discussed in the previous chapter, mixed ethnicity individuals were categorised according to their minority (and most marked) ethnicity by clinicians. Although these categories have been criticised for ‘essentialising’ culture and phenotype (Bhopal et al., 1990; Frankenberg, 1994; Aspinall, 2001, 2003), they nonetheless reflect clinicians’ overarching categorisation of patients and will therefore reflexively be employed.

The number and percentage of ‘racial matches’ and ‘transracial matches’ made at each clinic over the period of observations are illustrated in Table 6.4 (Creative Fertility) and 6.5 (The Fertility Centre) below. The cells in green represent ‘racial matches’ between donors and recipients whilst the cells in blue represent ‘transracial matches’ (as classified for the purposes of this study).

Table 6.4: Recorded Ethnicity of 152 Matched Donors and Recipients over 10 months, Creative Fertility

Creative Fertility		Recipient Ethnicity				
		White	Black	South Asian	Chinese	Total
Donor Ethnicity	White	90% (135)	1% (2)	1% (2)	1% (2)	93% (141)
	Black	0% (0)	3% (4)	0% (0)	0% (0)	3% (4)
	South Asian	1% (2)	1% (2)	2% (3)	0% (0)	4% (7)
	Chinese	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
	TOTAL	91% (137)	5% (8)	3% (5)	1% (2)	100% (152)

Table 6.5: Ethnicity of 65 Matched Donors and Recipients over 13 months at The Fertility Centre

The Fertility Centre		Recipient Ethnicity				
		White	Black	South Asian	Chinese	Total
Donor Ethnicity	White	42% (27)	1% (1)	17% (11)	0% (0)	60% (39)
	Black	0% (0)	14% (9)	0% (0)	0% (0)	14% (9)
	South Asian	0% (0)	3% (2)	22% (14)	0% (0)	25% (16)
	Chinese	0% (0)	0% (0)	0% (0)	1% (1)	1% (1)
	TOTAL	42% (27)	18% (12)	39% (25)	1% (1)	100% (65)

As illustrated by the tables above, at both clinics the majority of transracial matches (blue cells) were made between white donors and BME recipients, followed by donors and recipients from different minority ethnic backgrounds, and lastly, a minority of matches were made between BME donors and white recipients at Creative Fertility only. At Creative Fertility, transracial matches accounted for 5% (n=10) of 152 matches recorded, whilst at The Fertility Centre, transracial matches accounted for 21% of the 65 matches recorded (n=14). This difference in the percentage of

transracial matches between clinics was shaped by the supply and demand of BME donors and recipients at each clinic, by clinicians' perceptions of skin tone (which was related to clinicians' own ethnicity) and by clinicians' beliefs about 'race' and reproduction. The figures in the tables above will be discussed in more depth below, alongside clinicians' discourses of transracial matching.

Clinicians' negotiations of transracial matching illuminated the ways in which clinicians mediated the crossing of normative racialised kinship boundaries and the nuanced ways in which they acted upon patients' characteristics in ways that stratified and racialised reproduction and medicalisation in new and complex ways.

6.5 'Transracial' Matching: Negotiations of 'Race'

'Transracial matching' refers to the matching of donors and recipients from different 'racial groups', i.e. white, black African/Caribbean, South Asian and Chinese. This includes matching donors and recipients from white and BME backgrounds (e.g. white and South Asian) and also matching donors and recipients from different minority ethnicities (e.g. South Asian and black African). This section explores the context in which clinicians made transracial matches and how clinicians strategically naturalised, de-naturalised and re-naturalised donor and recipient characteristics for the purposes of making a match.

As mentioned above, 'transracial matches' accounted for 5% of all matches at Creative Fertility and 21% of all matches at The Fertility Centre. Of these, the majority of matches 'transracial matches' made by clinicians were between white donors and BME recipients, which accounted for 3% (n=6) of all matches at Creative Fertility and 18% of matches at The Fertility Centre. This was followed by matches between South Asian donors and black recipients, which accounted for 1% (n=2) of

matches at Creative and 3% (n=2) of matches at The Fertility Centre. Finally, a BME donor was allocated to a white recipient in 1% (n=2) of matches at Creative Fertility and in no cases at The Fertility Centre.

Clinicians' navigation of 'transracial matching' revealed how reproduction was stratified through clinicians' willingness, and unwillingness, to match donors and recipients from different 'racial' backgrounds. As will be explored below, the types of families that were valued by clinicians and the types of families that were less valued by clinicians shaped the types of families they sought to reproduce through egg donation and their matching practices. Clinicians' navigation of 'racial difference' in matching was especially revealing of the role that clinicians played in reproducing racialised hierarchies and regulating the 'reproduction of whiteness'.

As will be shown, although clinicians were willing to match white donors to BME recipients, albeit with certain caveats, they were *unwilling* to match BME donors with white recipients. Below, clinicians' perceptions and practices of 'transracially matching' BME recipients will be explored, followed by their views of 'transracially matching white recipients.

6.5.1 BME Recipients: Curtailing Whiteness

At each clinic, the imposition of 'race' as a primary matching criteria had particular implications for BME recipients. A shortage of BME donors meant that BME recipients waited much longer to be matched than their white counterparts and in some cases this meant that some BME recipients might not be matched with a donor or receive treatment at all. Although The Fertility Centre had a higher proportion of BME donors the demand for these donors (by BME recipients) still outstripped their supply. In this context, clinicians re-conceptualised 'race' as being negotiable and

flexible, to an extent. Thus, despite otherwise framing ‘racial difference’ as a risk to the ‘welfare of the child’, all of the clinicians in this study not only saw it as “reasonable” to match white donors with BME recipients but framed this as a necessary compromise for recipients, i.e. to prevent delays to their treatment, as explored in Chapter 5.

However, despite clinicians’ willingness to allocate white donors to BME recipients, this practice was only seen as acceptable with certain caveats (recipients’ motivation aside), which will be explored below. The overarching theme in clinicians’ discourses and practices appeared to be a motivation to limit the degree of ‘whiteness’ in BME recipients’ reproduction, with the implication of further stratified particular BME recipients’ access to particular types of donors. Clinicians’ imposed several caveats in relation to matching white donors to BME recipients. These included: leaving recipients to wait longer to be allocated a white donor; restricting the ‘type’ of white donor they could be allocated; and restricting the ‘type’ of BME recipient that could be allocated a white donor. These factors will now be discussed in turn, below.

Before allocating a white donor to a BME recipient it was typical for clinicians to leave that recipient waiting longer for such a match. That is, BME recipients who were willing to accept a white donor would be left waiting longer than their white counterparts to be matched with a white donor, as illustrated by the quote below from Anna. This appeared to be done in case a ‘racial match’ could be found for the BME recipient.

“But we would still try primarily to match them [BME ORs] with someone of the same ethnic group, and we’ll usually leave them waiting longer, and after, you know, a fairly long wait, we’ll approach them with a white donor”[Anna, Creative Fertility]

During observations of matching sessions at Creative Fertility, when a BME recipient showed up at the top of the waiting list for a white donor, clinicians questioned her position on the waiting list (because she were not white) and often scrolled past her without further consideration, in search of a more “appropriate”, white, recipient. Clinicians also distinguished between the ‘type’ of white donors that they saw as being acceptable to allocate to BME recipients, particularly at Creative Fertility. BME recipients were predominantly allocated ‘marked white’ donors, e.g. from Algeria, Iran, Morocco and Portugal, who had previously been declined by white British recipients (as will be explored in Chapter 8). BME recipients were seldom matched with white British donors.

During observations, it wasn’t uncommon to hear clinicians comment that a particular ‘marked white’ or “Mediterranean” donor “looks Indian” or “looks African” before allocating them to BME recipients. Clinicians typically sought to allocate ‘marked white’ donors, with ‘darker hair and eye colour and olive skin tone’, to BME recipients, as illustrated by the quote below from Anna:

“Even if someone’s white, again, we would try to make sure they’ve got darker colouring, darker hair, skin tone, things like that.” [Anna, Creative Fertility]

Clinicians thus conceptualised BME recipients as being closer in phenotype to ‘marked white’ donors than to white British recipients, and in some cases, even to BME donors, as illustrated by the quote below from Mrs. Redwood:

“I remember matching an Indian lady with an Iranian origin, Iranian donor, because it was closer to her looks than some Indian donors who are much darker.” [Mrs. Redwood, Creative Fertility]

Clinicians thus conceptualised ‘marked white’ donors as having a flexible ‘race’ and being able to ‘pass’ as BME. However, clinicians did not see it as acceptable to

allocate 'marked white' donors to all BME recipients equally. Instead, the permissibility of this practice further stratified reproduction, and (bio)medicalisation (i.e. recipients' access to donors), based on racialised hierarchies of skin tone.

When questioned about 'transracial matching', clinicians typically replied that they saw it as "reasonable" and "acceptable" to match white donors with South Asian and Chinese recipients. However, clinicians were hesitant/ambiguous about allocating white donors to black African/Caribbean recipients, as reported in previous surveys of clinicians (Birdsall and Edwards, 1996; Murray and Golombok, 2000) and when asked about this practice they frequently slipped into talking about the acceptability of matching white donors to BME recipients more generally or to South Asian and Chinese recipients specifically.

Clinicians often conflated categories of 'ethnicity' and skin tone and drew on taken for granted racialised hierarchies of skin tone to contextualise their perceptions of matching. The quote below, from the counsellor at Creative Fertility, illustrates clinicians' reluctance to match white donors with black recipients because they were seen as being at the opposite ends of the 'racial' spectrum:

"So if they had a white donor they wouldn't say 'we'll match her with this lovely black lady', they wouldn't do that automatically. I don't think that would happen. But there's lots of in betweens [...] So I don't think necessarily it would be black and white matched together, but there's a shady area in the middle." [Linda, Creative Fertility]

Thus the 'ethnicity' and skin tone of BME recipients - or rather clinicians' perceptions and classification of these characteristics - directly stratified their access to white donors. However, it was not just the 'ethnicity' and skin tone of donors and recipients which were taken into account by clinicians when matching. Interesting, the

‘ethnicity’ and skin tone ascribed to BME recipients’ partners was also a primary determinant of BME recipients’ access to white donors.

In essence, clinicians saw it as acceptable to allocate a white donor to a BME recipient with a BME partner (i.e. to a BME couple), they would not allocate a white donor to a BME recipient with a white partner. The quotes below from clinicians at each clinic provide an insight into the complexities involved in clinicians’ decision-making and their navigation of racialised reproduction:

“So, if the wife is black and the husband is black [figures it out]... in this situation, they may not only accept a black, they would accept a white as well. And in the other situation, where husband is white and the wife is black, if they had a white donor, the child would be completely white, so they would not accept that. So in that situation, they would be happy for the child to be black black, or mixed, but not completely white” [Doctor Demetrious, Creative Fertility]

“For example, when the recipient is Indian and the husband is also Indian, they will say ‘I can accept a white donor’. But if the recipient is Indian and the husband is white, and she uses an egg donor who is white, that means the child will be totally white, so we don’t give them. If the partner is Asian, it is different, then we can offer.” [Doctor Rana, The Fertility Centre]

Such negotiations add another layer to stratified reproduction, in which some reproductive futures are valued and encouraged whilst other futures are ‘despised’ and discouraged (Ginsburg and Rapp, 1995b). That is, whilst clinicians saw it as acceptable for a BME recipients (of marked ethnicity) to have a mixed ethnicity child (of marked ethnicity), and enabled the reproduction of these families, they did not see it as equally acceptable for BME recipients to have a “totally white” child (of unmarked ethnicity), and avoided this type of reproduction. During observations, sometimes clinicians would comment that the ‘genes’ or ‘sperm’ of the recipient’s BME partner would ‘balance out’ the skin tone of the child, i.e. make it darker, so that the child would be ethnically marked, like the recipient.

Ethnographic observations of clinicians' practices of matching, as outlined in Tables 6.4 and 6.5 (above), showed that on the whole, clinicians' practices of matching BME recipients reflected their discourses of matching according to racialised skin tone. At Creative Fertility, a small minority of white donors were allocated to black African/Caribbean, South Asian and Chinese recipients in an equal number of cases (n=2 each). However, even these figures disguise important complexities within each case. For example, the 2 matches between a 'white donor' and a 'black African/Caribbean' recipient both involved the same 'black African' recipient, who was also labelled as being "light skin Arab". Therefore this 'black African' recipient was seen as 'marked' as possessing a flexible 'race', i.e. as something other than 'black', which made it more acceptable to match her with a white donor (which clinicians were otherwise hesitant to do).

At The Fertility Centre on the other hand, where there was a higher number of BME recipients, clinicians allocated white donors to South Asian recipients in 17% of cases but only allocated a white donor to a black recipient in 1% of cases. Clinicians also allocated a South Asian donor to a black recipient in 2 cases at each clinic (n=4). However, no matches were made between black donors and South Asian recipients. Informal discussions with clinicians revealed that they didn't match black African/Caribbean donors with South Asian recipients because they thought that South Asian recipients would refuse these donors based on their dark skin tone. On the other hand, clinicians saw black African/Caribbean recipients as being more "open" to accepting South Asian donors on the basis that these recipients sought donors with donors with darker skin tone and saw "South Asian skin tone" as a more acceptable compromise than 'white skin tone'.

The findings that clinicians were reluctant to match white donors with BME recipients echo the findings of previous quantitative surveys on clinicians' views in the UK

(Birdsall and Edwards, 1996; Murray and Golombok, 2000) and qualitative studies which have touched on clinicians' views (Campbell, 2007; Steinberg, 1997; Price, 1997; Klotz, 2014). However, as illustrated above, clinicians' discourses and practices were more nuanced than simply answering 'yes' or 'no' to the question of 'transracial matching'.

Clinicians' nuanced negotiations of matching BME recipients illustrate how clinicians stratified reproduction through seeking to curtail and contain whiteness for BME by restricting the type of white donors they could access and the type of BME women who could access them. On the other hand, clinicians' perceptions of matching white recipients revealed a primary concern with maintaining whiteness within white families, as will be discussed below.

6.5.2 White Recipients: Maintaining Whiteness

For white recipients clinicians' primary concern was to maintain (not curtail) the degree of whiteness in their reproduction. When clinicians were asked whether there were any types of matches that they would not make, all were adamant that they would not be willing to allocate a BME donor to a white couple. Clinicians could not envisage making such a match unless it was specifically at the 'insistence' of white recipients (which they had not previously experienced). Unlike BME recipients and 'marked white' donors, for whom clinicians saw 'race' as flexible (albeit it with several caveats), for white (British) recipients, 'race' was regarded as inflexible and bounded.

Clinicians drew on a different set of values and concerns in relation to matching BME donors with white recipients (compared with matching white donors with BME recipients). Here, clinicians did not draw on the semantics of 'supply and demand'.

Neither did they merely highlight the negative socio-cultural consequences of a lack of resemblance between recipients and their child on the welfare of the child. Instead, clinicians drew on naturalistic assumptions about ‘race’ and reproduction and saw it as unnatural and unethical for a white couple to have a ‘black’ child, and more specifically, for a white woman to *give birth* to a ‘black’ child in the absence of a BME partner. This echoes findings from Deomampo’s (2015) study in India, where clinicians were reluctant to match South Asian donors with white recipients, although they did make such matches (unlike the clinicians in this study). The quote below from Jemma illustrates clinicians’ refusal to allocate BME donors to white recipients on the grounds of this going against ‘nature’ and the welfare of the child:

“I wouldn’t be comfortable myself. Because as a white couple you can’t have a natural black baby. Do you know what I mean?! I would just feel uncomfortable. Ethically, it wouldn’t be good for the child as well, that kind of thing. More a welfare of the child issue than anything.” [Jemma, Creative Fertility]

“If the child is going to be a completely different race to their parents, you know, we wouldn’t do that. So we wouldn’t offer a white recipient a black donor, an Asian donor or that sort of thing. Definitely wouldn’t do that. That’s the main one, given that the mother is going to be giving birth to the child, I think that’s one of the main reasons” [Anna, Creative Fertility]

At The Fertility Centre, no matches were made between BME donors and white recipients. At Creative Fertility, clinicians allocated South Asian donors to white recipients in 2 cases, as illustrated in Table 6.4, despite being vehemently opposed to this in theory. However, in each case, the 2 white recipients concerned were both ‘marked white’, i.e. Algerian and Moroccan, which appeared to supersede clinicians concerns about a lack of ‘racial resemblance’. That is, clinicians foregrounded these white recipients’ ‘markedness’ over their ‘whiteness’. The excerpt below is from an

informal conversation with Anna, which illustrates her reasoning for allocating a South Asian (Pakistani) donor with an Algerian recipient:

“Anna and I talked about what Algerian peoples’ skin colour looks like. I said I didn’t know. Anna said she assumed that it would be like South Asian skin tone, hence previously offering this Algerian recipient a Pakistani donor who had light skin tone” [Field note, week 19, Creative Fertility]

Interestingly, Anna also appeared to draw on the Pakistani donor as possessing both a marked and flexible ‘race’ by describing her skin tone as ‘light’, and something other than ‘normal’ Pakistani skin tone, thus making it more acceptable to allocate her to a ‘white’ recipient. Clinicians’ concerns about maintaining ‘pure white’ racialised boundaries (Szkupinski-Quiroga, 2007), and their innovative ways of navigating these to make a match, were also apparent in their negotiations of matching ‘marked white’ donors with white British recipients, something which they otherwise tried to avoid.

Clinicians’ hesitancy to match ‘marked white’ donors with white British recipients was in part due to their experience of white recipients’ declining ‘marked white’ donors when they were offered to them (as will be explored in Chapter 8). However, clinicians also displayed some concerns about white British recipients having a child who would look ‘too different’ from its parents if it had ‘olive’ skin tone. Such concerns did not preclude clinicians from making such matches however, although when they did, they strategically naturalised and normalised (Thompson, 2005) the ‘olive’ skin tone of donors as ‘light/fair’ by foregrounding or minimising the role of genes in determining donors’ skin tone. Such strategies enabled clinicians to ‘unmark’ the whiteness of these donors so that they could be matched with white British recipients, as will be shown below.

When classifying white donors’ skin tone, clinicians foregrounded white donors’ ‘ability to tan’ as an indicator of their ‘natural’ and genetic inheritable skin tone (as

explored in Chapter 5). However, when seeking to ‘unmark’ white donors, clinicians contextualised donors’ ‘tanned’ skin tone as being due to them coming from sunny countries (and thus not as being due to their inheritable genetic make-up). As such, clinicians reasoned that in the UK, which has less sun than the donors’ countries of origin, these donors would have ‘lighter’ (natural) skin tone than they would otherwise have, making it acceptable to allocate them to white British recipients, as illustrated by the field note excerpt below:

‘After they matched the donor from Columbia with a white British recipient they worried that the donor might be darker in skin tone than the recipient. They pulled out a passport photo of the donor and looked at her to deem her skin colour. Jemma said the difference in skin colour would be fine. Doctor Ali said that in her photograph the donor probably would have been in Columbia and so would have had a tan, which she probably wouldn’t have in the UK. [I don’t know how they could tell- the passport picture was black and white]’
[Field notes, week 17, Creative Fertility]

On another occasion, clinicians were concerned about matching a white British donor with a white British recipient because the donor was marked as having “olivey” skin tone. As with the above example, clinicians reasoned that the donor had ‘tanned’ skin tone because she had been travelling in India that summer. However, here, clinicians foregrounded the role of genetics in determining the donor’s ‘natural’ skin tone (not the environment), by drawing on the ethnicity of her parents and grandparents, all of whom were white British. This strategic naturalisation enabled clinicians to normalise, and ‘unmark’ the donor’s “olive” skin tone by reconceptualising it as being ‘naturally’ (genetically) “fair”.

As illustrated in this section on ‘racial matching’, clinicians’ perceptions and practices of matching were nuanced, complex and contextual. Skin tone rather than ‘ethnicity’ was the most prioritised matching criterion by clinicians. Although clinicians were willing to negotiate the boundaries of ‘racial difference’, their practices ultimately

reinforced and reproduced existing racialised hierarchies and inequalities. Whilst clinicians' negotiations of racialised hierarchies were central to their practice of matching for physical resemblance, it is important to note that other (unrelated) categories and contextual factors also shaped clinicians' practices of donor allocation.

As seen in the previous chapter, clinicians classified recipients as 'good' or 'demanding' based on recipients' compliance with clinicians' expectations of the recipient role. Below, some of the ways in which these classifications impacted clinicians' matching practices will be explored.

6.6 'Demanding' Recipients: Delaying Matching

Clinicians' perceptions of recipients as 'demanding' and 'difficult' sometimes shaped decision to matching, or rather *not match*, particular recipients. Here, clinicians avoided matching recipients whom they saw as 'demanding' and often left these recipients to wait longer to be matched with a donor.

Sometimes nurses avoided matching recipients whom they constructed as being "too difficult" because they wanted to avoid supporting them through their treatment cycle, which they would have been required to do after matching them. This was particularly the case at Creative Fertility, where a larger supply of recipients meant that nurses could afford to be more discerning about which recipients to match and where the number of on-going treatment cycles was much larger than at The Fertility Centre. It was common to see nurses skip over recipients at the top of the waiting list, reasoning that they were "too fussy" or "too picky" and so would not accept or were not deserving of the donor under consideration.

For example, during one matching session at Creative Fertility one recipient, Julia, showed up near the top of the waiting list for a donor. However, the nurses concluded that Julia would be ‘too difficult to deal with’ during her treatment and so they avoided matching her with a donor in that matching session (and in several subsequent sessions), as illustrated by the short excerpt below from observational field notes:

“When Julia, the next recipient, showed up as a potential match for a donor the nurses and doctor all chorused ‘Oh no, we’re not going to match to her, she would be a nightmare to have to go through treatment with. We’re not ready to deal with her yet’. And they carried on searching for another recipient” [Field notes, Week 31, Creative Fertility]

Nurses were especially reluctant to match ‘demanding’ recipients when they were particularly busy. For example, over one period of observations at Creative Fertility the head nurse had gone on holiday for several weeks. The remaining nurse, Jemma, was concerned about co-ordinating and supporting matched donor and recipient through their treatment cycles alone and sought to minimise any disruption to her workload during her colleague’s absence. In one matching session, having hesitantly matched one recipient (Suzanne) who was regarded as a “nightmare” because she had declined ‘lots of donors’, Jemma avoided matching a second recipient (Carmel), who was also regarded as being “difficult” on account of having lots of preferences for donor characteristics. This meant that the Jemma would not have to support and manage the treatment cycles of too many “difficult” recipients at the same time, particularly whilst she was doing this alone.

This scenario is illustrated by the field note below:

“When the next recipient, Carmel, showed up as a potential match for this donor, the nurse and doctor groaned. On Carmel’s profile it stated that she “wants very slim donor, in 20’s”. Jemma [the nurse] complained ‘I can’t deal with both Carmel and Suzanne (the ‘difficult’ recipient whom had just been

matched a moment ago) at the same time while Anna [the head nurse] is away'. Jemma skipped over Carmel's name and carried on going through the list looking for another recipient" [Field notes, week 34, Creative Fertility]

Nurses' practices of not matching particular 'difficult' recipients thus enabled nurses to manage their own emotional labour and their busy workloads. However, clinicians also saw the practice of not matching recipients, and delaying their allocation of a donor, as serving another purpose. A pervading theme in clinicians' discourses was the view that recipients' preferences for donor characteristics would "soften over time", i.e. that recipients would be more willing to compromise on their preferences and accept a donor under offer. There was a general perception amongst clinicians that the longer recipients waited to be matched the more likely they were to accept a donor. The quote below from Doctor Demetrious illustrates this view:

"There are more fussy patients than others, but after a while they tend to become less fussy because time is of essence" [Doctor Demetrious, Creative Fertility]

Thus, sometimes particular 'demanding' recipients were not matched for weeks, and even months, based on the assumption that these recipients would become more cooperative and more likely to accept a donor after spending longer on the waiting list. Thus making a match for commercial purposes was not always a top priority for clinicians. On a couple of occasions recipients who were labelled as 'demanding' by clinicians at each clinic (on account of declining multiple donors) had left the clinic because they felt that clinicians had taken too long to match them with a 'suitable donor'. Thus clinicians also stratified (bio)medicalisation, whereby some types of recipients were subject to the disciplinary/exclusionary aspects of (bio)medicalisation based on their 'non-compliant behaviours' (Clarke et al., 2010: 83)

6.7 Conclusion

This chapter explored clinicians' conceptualisations, prioritisations and negotiations of formal and informal matching criteria. In order of least importance, these the matching criteria imposed by clinics and clinicians included the recipient waiting list, recipients' preferences and physical resemblance ('secondary matching criteria'), which were superseded by 'medical characteristics' (i.e. height/weight and CMV status) and 'race' ('primary matching criteria'). Clinicians' perceptions of recipients as 'demanding' and 'difficult' also shaped their matching practices, primarily with regards to not matching particular recipients.

The findings presented in this chapter illustrate how clinicians' discourses and practices of matching revealed a medicalisation and racialisation of reproduction and the stratification of reproduction and medicalisation according to nuanced racialised cleavages. I showed, for example, how clinicians' prioritisation of matching criteria varied when clinicians were matching white recipients or BME recipients, prioritising different criteria in different contexts of matching.

At both clinics, clinicians saw a primary aim of their role in matching as protecting the medical and social welfare of children born through egg donation. At both clinics, 'medical' matching characteristics were imposed by clinicians to ensure the safety and protection of donor-conceived children and recipients of donor eggs. However, the prioritisation of different medical matching criteria at each clinic illuminated the socially constructed nature of these medical categories, as did clinicians' willingness to compromise on these criteria when matching BME donors and BME recipients.

The differential treatment of BME recipients also illuminated clinicians' prioritisation of 'race' as the most important matching criterion more generally (as will be shown below). However, whereas for BME recipients clinicians saw 'race' as an overriding

Master Status (over and above their medicalised matching characteristics), for white recipients, clinicians took for granted that the ‘race’ of recipients would be matched and so ‘race’ was one of multiple Master Statuses (alongside their medicalised criteria, their preferences and their physical characteristics).

Clinicians saw ‘race’ as the most important criterion of matching and as protecting the social welfare of children born through egg donation. Fundamentally, clinicians singled out ‘race’ as a primary indicator of kinship and ‘racial difference’ as a primary kinship risk, i.e. to the display of kinship resemblance. Clinicians’ discourses and practices of ‘transracial matching’ were particularly revealing of clinicians’ conceptualisations of ‘race’ and reproduction, their role in the reproduction of whiteness and the nuanced ways in which matching stratifies reproduction and medicalisation.

Clinicians took intricate steps to navigate ‘transracial matching’ with the aim of limiting ‘racial difference’ between donors and recipients, and between recipients and their child. In doing so, clinicians sought to curtail BME recipients’ reproduction of racialised white features whilst maintaining the reproduction of racialised white features of white British recipients. For example, BME recipients’ access to white donors was dependent on clinicians’ perceptions of their skin tone, the skin tone of their partner and skin tone of white donors. On the other hand, when matching ‘marked white’ donors with white British recipients clinicians strategically ‘unmarked’ the whiteness of these donors. Whilst clinicians saw it as acceptable for a BME couple to have a mixed ethnicity child they did not see it as equally acceptable for a white couple to have a mixed ethnicity child.

These discourses and practices of ‘transracial matching’ reveal how an analysis of matching in the present contexts adds new layers to the stratification of reproduction

and (bio)medicalisation. It was illustrated how the reproduction of ‘racially congruent’ families (Wade, 2012) were valued and encouraged, whilst the reproduction of ‘racially incongruent’ families (ibid) were devalued and discouraged. Reflecting the regulatory context in which matching took place, this stratification was not based on money but on moralised concerns about the welfare of the child. In this context, ‘race’ and ‘ethnicity’ are depicted as a ‘risk’ by clinicians, to be managed, and not just as a commodity (as argued in the literature).

Descriptive statistics of ‘racial matching’ at each clinic enabled insight into the patterns and outcomes of clinicians’ matching practices and revealed that clinicians’ practices were coherent with their perceptions and that the majority of allocations made by clinicians were ‘racially’ matched. This has significant repercussions for the types of families that were reproduced in the clinics through egg donation. Finally, this chapter illustrated how clinicians’ perceptions of recipients as ‘demanding’ shaped their practices of matching whereby they avoided matching ‘non-compliant’ recipients as a mechanism of managing their own workload and managing the expectations of recipients. The strategy of *not matching* particular recipients was undertaken with the aim of neutralising recipients’ active and non-compliant agency (declining donors) into a passive and compliant form of agency (accepting donors).

Taken together, these findings demonstrate that the ways in which clinician’s allocation of donors to recipients illustrate a medicalisation, stratification and racialisation of reproduction. Clinicians sought to reproduce a normative model of the family through discourses of ‘risk’, ‘racialisation’ and ‘strategic naturalisation’ by strategically managing the crossing of normative racialised boundaries.

Chapter 7: Recipients' Preferences for Donor Characteristics

7.1 Introduction

In the current chapter recipients' own accounts of their preferences for donor characteristics will be explored. Recipients' preferences for donor characteristics refers to the characteristics that recipients were willing, or unwilling, to accept in their donor. This will include exploring the meanings that recipients attached to resemblance, the characteristics that they prioritised when stating their preferences, and the characteristics that they sought to exclude from their reproduction. Recipients' preferences for information about donors will also be explored, including recipients' views of the amount of donor information they were provided with.

As highlighted by Braverman and Frith (2014) and Zadeh et al. (2016a), in the UK clinical context of egg donation little is known about the preferences that recipients request in practice or how the clinical context shapes recipients' preferences. Ethnographic studies on egg donation in the UK have reported that an extreme shortage of donors that recipients were unable to state preferences for donor characteristics with the clinics under study (Konrad, 2005; Klotz, 2010). Studies which have explored recipients' preferences for donor characteristics have reported that recipients wanted a donor who resembled their own characteristics (Hayden, 1995; Becker et al., 2005; Konrad, 2005; Mamo, 2005; Thompson, 2005; Hargreaves, 2006, Harrington et al., 2008; Cadoret, 2009; Nordqvist, 2010) and/or who possessed characteristics which reflected euro-American ideals of beauty (Birenbaum-Carmeli and Carmeli, 2002; Nahman, 2006; Hudson, 2015). Researchers have also have reported that some recipients selected donors with characteristics which were

‘different’, and perceived as ‘better’, than their own as a way of “enhancing” their “family qualities” (Birenbaum-Carmeli and Carmeli, 2002; Mamo; 2005; Nahman, 2006; Nordqvist, 2010).

Recipients’ preference for donor information in this chapter refers to how recipients conceptualised donor information (in general) and whether they wanted more information (Broderick and Walker, 1995; Stuart-Smith et al., 2002; Rubin et al., 2015). The findings below reflect interviewees’ retrospective accounts of stating their preferences with the clinic. Ethnographic data on recipients’ informal preferences (their additional preferences, stated as free-text) and recipients’ formal preferences (their stated ‘tick-box’ preferences which specified which specific donor characteristics they were willing, and unwilling, to accept) will also be drawn upon.

7.2 Recipients’ ‘Desire’ for Resemblance

Recipients expressed various attitudes towards egg donation, which in turn appeared to shape their preferences for donor characteristics. Many recipients reported originally being “strongly against” the idea of using egg donation, having never considered it in the past. However, after being recommended to use egg donation by multiple healthcare professionals and after hearing success stories through the media and their social networks, recipients re-conceptualised egg donation from being a “crazy” option to being “the only option” (Franklin, 1997) and the “next logical step” in what had by then become recipients’ assisted fertility journey. Recipients thus drew on a medicalised discourse in rationalising their need for egg donation, as illustrated by the quote below from Tina:

“At the time when we did our own IVF, we weren’t interested in egg donation at all. At the time we were strongly against it. It was somebody else’s, not ours, which was my opinion at the time [...] Actually, the last clinic suggested

egg donation, and I said I'm not going to contemplate that. Then I came to The Fertility Centre and they suggested egg donation. So I thought 2 clinics can't be wrong, maybe I need to look into it. After speaking with Doctor Rana it didn't sound like a bad idea at all, it sounded like our only option really." [Tina, The Fertility Centre]

As acknowledged by feminist researchers, in their desperation for a child of their 'own', women felt they had no choice but to try to conceive through egg donation (Franklin, 1997), a view that was shaped by wider assumptions and expectations about motherhood as natural for women (Russo, 1976). Several recipients described "grieving" as part of the process of using donor eggs, which involved recipients mourning their inability to have a genetically related child and the physical resemblance that might accompany this, as illustrated by the quote below from Betty:

"There was that process of having to grieve, from my point of view, of not being able to have my own genetic child. That you look in the mirror and think I'm not going to see anything. So we had to go through that period, myself, and then as Nick [partner] says, because we wanted to have a family together, so donor eggs were the only option." [Betty, The Fertility Centre]

Even after deciding to use (anonymous) egg donation, many recipients spoke about having to 'coming to terms with' using donor eggs as an ongoing process. Some recipients said that they were "still not 100% comfortable", "anxious" and "uncertain" about using egg donation and described their role as recipients in a precarious way (Franklin, 1997; Becker, 2000). These recipients felt alone and uninformed in navigating the meaning and consequences of egg donation, and described feeling like they were left with a "can of worms" in relation to the psychological impact of using donor eggs. In the context of donor anonymity, some recipients had anxieties about their donor being a stranger whom they would be unable to meet or see (despite not actually wanting to meet or see her).

Recipients wondered what their donor would contribute to their child, what biological contribution they would have in gestating their child and what this meant for their relationship to their child, as illustrated by the quote below from Joanne:

“There’s a whole other can of worms, emotionally and mentally, the fact that it’s egg donation. What’s not considered enough is the attachment thing, ‘cause it’s like, I know he’s my child in every sense of the word, but genetically he’s not [...] You’re kind of left going, I wonder what it means, in the sense of that genetic thing [...] What does the egg, in terms of the development of the child, physically, and mentally, emotionally and spiritually, how does it affect the child, or how much do I affect the child?”
[Joanne, The Fertility Centre]

Echoing findings from past studies, the majority of recipients in this study conceptualised egg donors as being a genetic and reproductive “substitute” for their own ‘genetic material’ in reproduction, which would otherwise have been passed down to their child through their own eggs (Konrad, 2005; Szkupinski-Quiroga, 2007; Thompson, 2009). Recipients assumed that the physical characteristics they shared with their donor would be genetically inherited by their child and consequently shared between themselves and their child. They therefore wanted a donor who would be a “credible genetic substitute” (Konrad, 2005) in the form of a close physical match to themselves:

“It was about choosing a donor within certain parameters that were close enough. It was about being close enough to me. Because, you know, it’s instead of my genetic make-up.” [Brenda, Creative Fertility]

Whilst recognising their own socialisation into accepting the use of donor eggs, recipients still felt stigmatised by wider society because they were infertile (involuntarily childless) and were using egg donation to reproduce (Becker, 2000, Murray and Golombok, 2003; Golombok et al., 2006). Recipients felt that egg donation deviated from normative models of natural reproduction, biological

motherhood and genetic kinship and as such was a “taboo” subject. Some recipients described adoption and sperm donation as being less stigmatised in society because they were more established routes to alternative family building, and did not challenge pre-existing conceptualisations of motherhood, as illustrated by the quote below from Betty:

“Adoption is more talked about now, it’s not so taboo. But I think egg donation is, and people don’t really understand it. If they’ve seen you as a woman having that pregnant belly it’s more difficult to actually say ‘this isn’t mine biologically’ [...] It [egg donation] shouldn’t be different from adopting a child or using a sperm donor. But I feel at this moment in time it kind of is. Because it is so newish” [Betty, The Fertility Centre]

Recipients were particularly concerned about deviating from the normative model of kinship resemblance, and the consequences of this for their child’s sense of belonging within the family, for the legitimacy of their family and their own identity as parents (Becker et al., 2005; Hargreaves, 2006, Harrington et al., 2008; Mamo, 2005; Nordqvist, 2010; Hudson and Culley, 2014). Drawing on a normative discourse of kinship resemblance – in which physical resemblance is seen as an indicator and reflection of a genetic and kinship relationship- recipients sought to construct resemblance with their child to enable their child to pass as ‘as if’ it were their own ‘natural’ and ‘genetic’ offspring (Ragoné, 1998; Finkler, 2000; Broderick and Walker, 2001; Becker et al., 2005; Mamo, 2005; Richards, 2006; Finch, 2007; Szkupinski- Quiroga, 2007; Mason, 2008; Marre and Bestard 2009; Nordqvist, 2010), as illustrated by the quote below:

“Because I wanted it to look as much of a natural baby for us as possible [...]. Because if the genetic thing was different looking, then there’s more of a thing for people looking twice” [Joanne, Creative Fertility]

Recipients saw a lack of resemblance between parents and children, in the context of non-genetic reproduction, as stigmatised and a risk to their display of kinship resemblance (Becker et al., 2005). They were concerned about encountering ‘resemblance talk’ through which others would question the belonging of their child and the legitimacy of their family by questioning the origins of their child’s difference with themselves (ibid). They saw having a child with characteristics that were “too different” from their own as “advertising” the use of a third party in their reproduction and as a kinship risk’, i.e. as a threat to their display of kinship resemblance. In order to manage this anticipated felt stigma (Scambler, 2004) recipients wanted their child to ‘pass’ as their own genetic offspring:

“So looking as though it could be a genetically natural part of our family. Well, why is that important? So I know [white British] friends with Chinese children who have adopted children from China and everything. All I can say is that I don’t want to be having the supermarket conversation all of the time. The kid might just want to be like ‘you know I’m just a normal kid, I don’t want to make a big deal of it.’” [Helen, Creative Fertility]

Recipients’ preference for resemblance was thus shaped by wider ideological constraints in which children are expected to resemble their parents (as a reflection of the supposedly defining genetic relationship between them). In this regard, recipients’ preference for resemblance might be interpreted as a form of self-surveillance (Clarke et al., 2010) in which they sought to minimise risk and reproduce a normative ideology of the family. Thus recipients felt they had little choice but to reproduce resemblance with their child as a way of managing the ‘felt stigma’ associated with their own infertility and the use of an egg donor.

By contrast, the white same-sex male couples (n=2) in this study displayed a different trajectory towards egg donation compared with the female heterosexual recipients discussed above. These same-sex male couples did not see infertility and egg donation

as stigmatised (neither of the couples had been diagnosed as medically infertile) and did not seek to match donors to the non-genetic father. Though only a small number of same sex male couples were interviewed in this study, the absence of their views in the literature and their different expectations of the matching process deserve some attention, particularly since their differing views contrasted with and illuminated the views of the female heterosexual recipients in this study.

The male couples in this study did not expect to reproduce naturally or even to become parents. They displayed little anxiety about using the donor eggs, which they framed as a biological, rather than medical, necessity. These couples were not referred to egg donation via healthcare professionals (instead relying on queer social networks) and did not feel compelled to use ARTs in the same way as female recipients, e.g. they spoke about egg donation as a “luxury” and lifestyle choice rather than as a necessity. They spoke about donors as a “tissue donor”, e.g. as a potential organ or tissue donor for their child in the future, rather than as a ‘genetic substitute’.

These couples did not seek to match the characteristics of their donor with the non-genetic parent because they did not seek ‘family legitimacy’ through kinship resemblance. Instead, they saw ‘kinship resemblance’ as part of a wider heteronormative framework which they did not have access to and did not seek to reproduce. Unlike the lesbian couples in Mamo’s (2005) and Nordqvist’s (2010) studies, but like the male same-sex recipients in Deomampo’s (2015) study, the same-sex male couples in this study did not seek to reproduce ‘racial resemblance’. Indeed, one couple conceptualised having a ‘black child’ (mixed ethnicity) as acceptable, and even desirable. This indicates how gender, not just sexuality, can influence recipients’ preferences (although the number of same-sex couples was very small in this study).

These couples saw having a child who looked different to themselves as consistent with their principles of valuing difference, a view which was informed by their own marginalised positions as a gay couple in a heteronormative society. Below is a quote from Milo and Dean which illustrates their view of “embracing difference”. The quote begins with Milo’s response to my question about whether the couple would have considered using a BME donor:

Milo: “To have a black donor? Of course! I don’t want to have the same as the rest. The heterosexual couples they are used to play with the normality, they don’t have to go against so many things. When we came out as gay people you have to confront so many issues about the society and you have to accept to have all the courage to accept yourself, and then to go outside, and you’ll be different. We don’t mind difference. I respect that what is normal for me, is not normal for you, all of us, we are different. We have to accept and respect the difference of each other. This is the main thing”

David: “So we embrace difference, because essentially we are considered different” [David and Milo, The Fertility Centre]

7.3 Preferred characteristics

Recipients discussed a variety of ideal preferences for donor characteristics and varied in relation to which characteristics they saw as important in their donor. In practice, recipients’ ability to state their preferences for donor characteristics was limited by the available categories in each clinic, the information collected about donors and clinicians’ willingness to allow them (as explored in Chapter 5). The focus in the current section will be on recipients’ retrospective accounts of stating their preferences for donor characteristics within the clinic (rather than merely their ideal-type preferences). Firstly, recipients’ preference in relation to donors’ health will be explored, followed by recipients’ preferences for ‘ethnicity’/“race” and general physical resemblance (eye colour, hair colour, height, weight) and lastly recipients’ preferences for socio-cultural resemblance.

Because of a shortage of donors most recipients were willing to negotiate their preference for resemblance and considered accepting donors with different characteristics to their own. Such negotiations will not be the focus of this chapter (as they will be discussed in the following chapter) but are mentioned here to reflect recipients' experience of stating their preferences and to contextualise recipients' preferences in practice.

7.3.1 Health

A primary aim for all of the recipients in this study was to have a healthy child through egg donation. In this respect, echoing the findings from previous studies (Lindheim et al., 2000; Mamo; 2005; Nahman, 2006), recipients saw the health of donors as the most important characteristic in their donor. "As long as it's a healthy baby" was one of the most commonly used phrases by the recipients in this study (albeit in different contexts), and this aim was prioritised over and above matching donors for resemblance, in theory, as illustrated by the quote below from Uzma:

"It doesn't matter, as long as it's a healthy baby, it could be any donor. We just want a positive result that is it [...] A healthy donor. Don't matter what it is." [Uzma, The Fertility Centre]

Recipients' preferences in relation to donors' health were less about their preferences of inclusion than their preferences of exclusion. Recipients sought to exclude donors whom they deemed as physically, mentally or genetically 'ill' or 'unhealthy', including donors who had medical history of "Downs Syndrome", "schizophrenia" "depression", or who were "obese" ('overweight'). Recipients saw these conditions as genetically inheritable and as a risk to the health and well-being of their child, as illustrated by the quote below from David (one half of a same-sex couple):

“It was really straightforward for us. The only thing for us, which they do for all donors, is that she had to be healthy, and that she wasn’t to be obese. And mental health too, like schizophrenia in the family, things like that [...] We mentioned that to Noreen [the nurse], but she said when they screened the patients they wouldn’t take on a donor that had any of those issues, otherwise that would have been the other concern.” [David, The Fertility Centre]

As illustrated by the quote above, recipients reasoned that having a ‘healthy’ donor was the responsibility of clinicians, who, unlike themselves, had the medical expertise screen donors and had access to donors’ medical information. Therefore, although the health of donors was an important consideration for recipients it nonetheless remained a theoretical concern. David’s quote (immediately above) also illustrates another pervading preference in recipients’ discourses, one which all recipients subscribed to: not having a donor who was ‘overweight’. When detailing their preferences for donors’ weight, recipients seldom discussed their preference for weight in terms of kinship resemblance. Instead, recipients conceptualised weight as a primary indicator of donors’ health and strategically drew on a discourse of health to exclude ‘overweight’ donors. Recipients foregrounded ‘overweight donors’ as a risk to their reproduction by posing a risk to the success of their treatment, as illustrated by the quote below from Brenda:

“There were concerns about the weight, in terms of what that meant for health, and even just the health going through the process.” [Brenda, Creative Fertility]

Recipients justified their exclusion of overweight donors by foregrounding their parental responsibility towards their child’s health and social well-being. Here, recipients emphasised the genetic inheritability of weight and described ‘overweight’ donors as a risk to their child’s health. Recipients simultaneously depicted donors’ weight as both due to genes –‘geneticisation’ (Lippman, 1991) - and individual responsibility – ‘healthcization’ (Conrad, 1987: 267) - in which they drew on

stereotypes about clinically overweight individuals being ‘unfit’, ‘lazy’, ‘unreliable’ and ‘lacking in self-discipline’, thus turning the moral into the medical (Conrad, 1992). In both of these conceptualisations ‘overweight’ donors were conceptualised as being genetically or culturally deviant and undesirable. Some recipients also described ‘overweight’ individuals as being subject to stigma and wanted to protect their child from inheriting a ‘weight problem’ and facing the social problems associated with this, as illustrated by the quote below from Aileen, who was referring to ‘overweight’ donors:

“You people have got to take responsibility in your own actions. Because at the end of the day you cannot stuff yourself. I hear a lot of cases of people saying ‘when I’m depressed then I eat’. If that’s the issue, you need to find out what it is that is making you depressed [...] It’s important for me because when you’re overweight it affects your health. And it affects you from doing so many things, physically. It will affect how you perform in real life. Because children go to school and get embarrassed and teased. Because it’s that child who has to go out and face the public.” [Aileen, The Fertility Centre]

7.3.2 Physical Resemblance

Recipients varied in the range of preferences they stated for donors’ physical and social characteristics. All of the female recipients who were interviewed and observed prioritised having a donor with the same ‘ethnicity’ and skin tone as their own. Many recipients also wanted a donor who matched their own general physical characteristics (hair, eye and skin colour, height and weight) and some recipients wanted a donor who matched their social characteristics (education and religion). Recipients’ prioritisation of their preferences, and their foregrounding of ‘race’/ethnicity, are illustrated by the quotes below from Betty and Amandeep:

“There’s a sliding scale of importance if you look at it. Between eye colour, hair colour, height and things; Overriding all of that, you’ve got to start with race, well, ethnicity, is a better way of putting it.” [Betty, The Fertility Centre]

“We weren’t really like into education, well we were, but it wasn’t the main category, a priority. The main criteria that we were looking for was being Indian. Punjabi if we could.” [Amandeep The Fertility Centre]

Recipients’ prioritisation of donor characteristics echoes the findings of previous studies (Klock et al., 1994; Le Lannou et al., 1997; Baker et al., 1998; Lindheim and Sauer, 1998; Lindheim et al., 2000; Broderick and Walker, 2001). Below, recipients’ meanings and negotiations of their preferences will be explored, starting with their preferences’ for ‘race’ and skin tone, followed by hair colour and eye colour and then ‘social characteristics’.

‘Race’ and Skin Tone

The samples of participants in previous European studies on matching have predominantly been comprised of white, middle-class female interviewees (Konrad, 2005; Bonaccorso, 2009; Nordqvist, 2010; Klotz, 2014). Therefore, there has been little insight into BME recipients’ preferences for gamete donors (Hudson and Culley, 2014) and little understanding of how these may differ from those of white recipients (Hudson, 2015). The interviewee accounts drawn upon in this current and following chapters include recipients who self-defined as white British, white European, South Asian (Indian and Pakistani), Chinese and black African. The ethnic diversity of this sample enabled insight into how recipients from different ethnic backgrounds conceptualised ‘race’ and ethnicity and the implications of this for their willingness, and unwillingness, to accept donors from a different ‘racial’/ethnic background.

All of the recipients who were interviewed spoke about ‘ethnicity’ as a genetically inheritable characteristic and as a proxy for skin tone and other physical characteristics, i.e. as ‘race’. They saw using an egg donor with the same ‘race’ as themselves as facilitating physical resemblance between themselves and their child

and enabling their child to ‘fit into’ their family, as illustrated by the quote below from Linda, a white recipient who had moved to the UK from Germany:

“Of course, it couldn’t be a black donor. We said we would only accept a white donor. But only for one reason, to fit into family. Not to be standing out from the beginning, at least to fit into the family. We are not a mixed couple.”
[Linda, The Fertility Centre]

Recipients saw ‘race’ as a primary indicator of kinship resemblance (Becker, 2000; Thompson, 2001; Fuscaldo, 2006; Mamo, 2005; Hargreaves, 2006; Wade, 2007; Nordqvist, 2010) and expressed concern that a lack of ‘racial resemblance’ between themselves and their child would lead to their child ‘standing out’ from their family. This view was shared by recipients across ‘ethnic’ backgrounds, as illustrated by the quotes below from Aileen, a black African recipient, and Amandeep, an Indian recipient, below:

“We made it specific to them, you cannot give someone to us who is white race. You can’t give a donor egg from the white race to the black race. As long as it’s black, I don’t mind. I am black, my husband is black, and if it’s a white baby people would say ‘how did that happen?’” [Aileen, The Fertility Centre]

“And we said we wanted an Asian donor [...] We wanted an Indian donor, just in terms of physical characteristics, Punjabi if possible [...] that’s the only reason that we didn’t want to go on the white side either, because you don’t want to make it too obvious.” [Amandeep, The Fertility Centre]

As illustrated by the quote above from Amandeep, most South Asian recipients wanted a donor from their own specific ethnic backgrounds, e.g. Indian Gujarati, Indian Punjabi or Pakistani, which they saw as being more reflective of their own physical characteristics. Although recipients from all ethnic groups saw having a donor of the same ‘race’ as a priority, they differed in their conceptualisation of this attribute and their willingness to accept a donor from a different ‘race’, as will be explored below.

White recipients were particularly concerned about their own *reproductive legitimacy*, and that of their *partner* when discussing the use of a BME donor. Some white recipients saw it as ‘crazy’ that they, as part of a white couple, could give *birth* to a ‘black child’. Here, like clinicians, white recipients conceptualised mixed ethnicity as ‘black’, rather than as white or mixed. Possibly, as women of ‘unmarked’ ethnicity (invisible and the ‘norm’), these white recipients could not conceive of ‘naturally’ giving birth to a ‘black child’ of ‘marked’ ethnicity (visible and ‘other’). Furthermore, white recipients were particularly concerned that if they had a ‘black child’ it would be their partner’s paternity and their own infidelity that would be questioned by others, rather than their own status as a genetic mother (Szkupinski-Quiroga, 2007), as illustrated by the quote below from Camille, a white recipient:

“Giving birth to a black child for me would be crazy. Because everyone would tell my husband, so you’re not the father, I had my child with another man. So no, it couldn’t have been a black donor basically.” [Camille, Creative Fertility]

Several white recipients (unprompted) said that they had wanted to adopt a ‘black child’ before using egg donation. There were a number of reasons underlying this decision, but of importance here is that recipients did not see an adopted child as their ‘own’ or intend to give birth to that child. Neither did recipients intend for an adoptive child to ‘pass’ as their own genetic offspring, as illustrated by the quote below from Camille (mentioned above):

“We also had an adoption project and we were ready to have a black child basically, because from the beginning, that child knows that it’s not genetically connected to us. So I wouldn’t have minded that.” [Camille, Creative Fertility]

BME recipients also wanted a donor from the same ‘racial’/ethnic background as themselves, although they help a more flexible conceptualisation of ‘race’, to varying

degrees. Because of a particular shortage of donors from individual BME backgrounds some of the BME recipients in this study had considered using a donor of a different ‘race’ and ethnicity to themselves (Szkupinski-Quiroga, 2007; Hudson and Culley, 2014).

During observations, some black African/Caribbean recipients were willing to accept white donors, although this was not very common. The main distinction *between* black African/Caribbean recipients was their willingness to consider South Asian donors, which seemed to depend on their conceptualisation of ‘race’, or ‘blackness’. Whilst some black African/Caribbean recipients were not willing to consider accepting South Asian donors because they did not see them as black, others took a more politicised, or one might argue ‘racialised’, view of blackness and said that they were willing to accept South Asian donors because they did see them as black. This latter view is illustrated by the quote below from Aileen, a black African recipient, who had rejected the possibility of using a white donor:

PD: *“So would you be willing to accept an Asian donor?”*

Aileen: *“Come on, it’s black [...] I wouldn’t mind. The only thing that matters to me is that it’s not 100% English white. It doesn’t matter whether it’s Asian, Caribbean, as long as it’s black. I don’t mind. Black is black.”* [Aileen, The Fertility Centre]

For the South Asian recipients in this study, skin tone held particular significance as both an indicator of kinship and as embedded in social norms of desirability and stigma. Most of the South Asian recipients in this study had “thought about” using a white donor. These recipients acknowledged the desirability of having a child with lighter skin tone (Thompson, 2001; Campbell, 2007; Braverman and Frith, 2014), although their main motivation for considering a white donor was to reduce delays to their treatment (Fogg-Davis, 2001; Pennings, 2001; Hudson and Culley, 2014).

Echoing findings from Hudson and Culley's (2014) study, the South Asian recipients in the current study distinguished between the 'type' of white donor that they were willing to accept. Although South Asian recipients were willing to accept donors with "olive skin tone", "dark eyes" and "dark hair", i.e. 'marked white' donors, they were less willing to accept white donors with 'racialised white features' such as light skin, blonde hair and blue eyes (Hudson and Culley, 2014: 239). South Asian recipients with a BME partner saw having a mixed ethnicity child, conceived using a 'marked white' donor, as being able to 'pass' as their own genetic offspring, as illustrated in the quote below from Amandeep, an Indian recipient:

"We were thinking about the British side of it, going for a white donor with dark hair and olive skin tone. Cause my niece she's got really fair skin. Her mum is Indian, and her dad, but she has a very fair complexion and green eyes. And if you saw my niece you wouldn't think she was Indian at all, she's just like English. You know because of the dark hair. We thought, what's wrong with that? [...] but then we thought no, deep down we do want Indian characteristics, skin colour and things." [Amandeep, The Fertility Centre]

Thus, despite otherwise acknowledging the desirability of having a child with lighter skin tone recipients sought to limit the degree of this in their donor, and child. This aim was also apparent from observations of recipients' informal preferences at each clinic. The below, just one of many similar informal statements of preference that South Asian recipients were observed to express in clinic, illustrates the ways in which South Asian recipients differentiated between the *types of white* donor they were willing, and unwilling, to accept, based on qualifications about donors' nationality and skin tone:

"Will accept Bangladeshi donor if light, Caucasian donor if dark, and Mediterranean, Egyptian, Middle Eastern, Turkish, Mexican and south American donor with dark/medium skin tone." [Field notes, week 20, Indian Couple's Informal Statement of Preference at Creative Fertility]

The above preference illustrates a more general theme amongst some South Asian

recipients, where the inclusion of white donors with darker skin tone (e.g. Mexican) was prioritised over and above the inclusion of South Asian donors with darker skin tone (e.g. Bangladeshi). Thus, in addition to distinguishing between types of white donors, South Asian recipients also distinguished between the types of ‘South Asian’ recipients that they were willing, or unwilling, to accept. Such distinctions between ‘racially matched’ donors were not limited to South Asian recipients. White British recipients also distinguished between the types of white donors they were willing to accept based on assumptions about their skin tone.

Of note here is that these white and South Asian recipients described their own skin tone as being “light” or “medium”; none described their own skin tone as ‘dark’. Although recipients were willing to accept donors whom they presumed to have ‘lighter’ or ‘similar’ skin tone to themselves then, they were less willing to accept a donor with ‘darker’ skin tone, as will be illustrated below.

Stigmatised Skin Tone: ‘Difference within Sameness’

Despite their emphasis on having a ‘racially matched’ donor, the white and South Asian recipients in this study distinguished between the types of ‘racially matched’ donors that they were willing or unwilling to accept. Whereas ‘racially matched’ donors with *lighter* skin tone than themselves were generally considered as acceptable by recipients racially matched donors with darker skin tone themselves were not. More specifically, these recipients sought to exclude donors from particular ‘racial backgrounds’ and nationalities which they associated with having darker skin tone. Such exclusions were evident in interviewees’ discourses and during ethnographic observations, as will be shown below.

White British interviewees often requested to be specifically matched with a ‘white British’ donor. Recognising that a shortage of donors might prevent this, some white

British recipients were willing to accept white donors from outside of the UK. However, this inclusion tended to be limited to donors from northern Europe on the basis that recipients presumed these donors would share their racialised fair racialised white features. This view is illustrated in the quote below from Brenda, a white British recipient:

“It was more about similarity to me. I’ve got a Celtic background, so it was the idea of pale skin, lighter eyes, that sort of thing. And again it was just to get a similarity. So if we had found out that they [donors] were from another country that shared some of those similarities, if they were from Denmark or something, that wouldn’t be a problem.” [Brenda, Creative Fertility]

On the other hand, many white British recipients were not willing to accept donors from Southern Europe or donors with “olive skin tone” and ‘darker features’, i.e. ‘marked white’ donors. These recipients perceived ‘marked white’ donors as having characteristics which they perceived as being ‘too different’ from their own and as a potential kinship risk. This view is illustrated by the quote below from Nick, the partner of Betty (both of whom were white British). Like most white British recipients who sought to exclude ‘marked white’ donors, Betty and Nick described themselves as having ‘fair skin tone’ and “blue eyes”:

“At the beginning when we were looking at donor eggs other doctors said go to Spain, where it’s done quite a lot. But we thought actually olive skin and brown eyes would be very different. And that might seem selfish in a way, when you put it like that, but it’s a substitute here, and so the matching process is important on that scale.” [Nick, The Fertility Centre]

Previous studies have also reported that white recipients travelling to other countries for egg donation distinguished between types of white donors (Nahman, 2006; Whitakker and Speier, 2010; Bergmann, 2011; Kroløkke, 2014; Homanen, 2018), although such distinctions of whiteness have been inherently shaped by the contexts

in which matching was explored. In this UK based study, recipients distinguished between types of donors based on their perceptions of donors from Southern and Eastern Europe as ‘other’ and donors from Northern Europe as ‘similar’.

Like white recipients, the South Asian recipients in this study used nationality and geographical ancestry as indicators of donors’ skin tone. As such, some South Asian (mainly Indian) recipients sought to exclude South Asian donors with geographical ancestry that they associated with having darker skin tone, including donors who came from Bangladesh, Kerala and South India. These recipients did not display similar concerns about having a South Asian donor with lighter skin tone, which was often depicted as desirable. It was not uncommon to see the informal preferences of Indian recipients, state: “Will accept Bangladeshi donor if light” or “No Bangladeshi or darker skin” [both from Indian recipients at Creative Fertility]. No Bangladeshi recipients were matched at either clinic during the period of observations, perhaps in part reflecting barriers relating to their lower socio-economic status compared with other South Asian ethnic groups (Modood et al., 1997).

In addition to conceptualising skin tone as a key indicator of kinship resemblance, South Asian recipients also saw skin tone as embedded in wider social norms of desirability and stigma, which held particular significance for their preferences. Here, South Asian recipients spoke about the social importance attached to skin tone in South Asian communities, and in society more generally, where lighter skin tone is regarded as more socially desirable and privileged and darker skin tone is seen as an undesirable difference, associated with stigma, marginalisation and discrimination.

Thus, unlike having a South Asian donor with lighter skin tone, these recipients saw having a South Asian donor with stigmatised darker skin as a kinship risk and as a risk to their child’s well-being, as illustrated by the quote below from Rabiaa, a

Pakistani recipient:

“In our Asian community, skin colour is important. Dark people don't do well, they get abused, treated badly [...] We might accept Indian, but not people from Bangladesh, South India, Kerala and Punjab, they are blacker people. We want the baby to be familiar with me and my husband and the family, to have the same colour, light skin, not a black baby, that would be too different. People in our community would see the difference.” [Rabiah, The Fertility Centre]

The exclusion of Bangladeshi donors by some Indian and Pakistani recipients was particularly evident from observations of recipients' formal preferences at Creative Fertility (where this information was quantifiable). Only a small number of recipients showed up on the waiting list for a Bangladeshi donor (n=3). On the other hand, there were over three times as many recipients on the waiting list for an Indian donor (n=>10). Despite acknowledging the undesirability of darker skin tone in South Asian communities, South Asian recipients with a white partner generally stated that the skin tone of their South Asian donor was not a primary concern. This is because these recipients assumed that their white husband's genes would lighten the skin tone of their child, as illustrated by the quote below from Ayesha, a Pakistani recipient with a white husband:

“For us you see things like complexion, that's just trivial to us really. Though also yes, my husband's English, I'm Asian, so it would probably balance out. We knew that, that wasn't a concern at all.” [Ayesha, Creative Fertility]

Eye Colour and Hair Colour

Many of the white recipients in this study had a preference for a donor with the same hair colour and eye colour as themselves, although these characteristics were more a prominent feature of white recipients' discourses. This was particularly the case for white recipients with 'lighter' eye colours (e.g. green or blue eyes), who often

reflected on the recessive nature of their eye colour. These recipients saw eye colour as a defining aspect of their self-identity and therefore as a central component of the physical resemblance that they wanted to replicate in their child. As such, recipients with blue/green eyes ideally sought to exclude donors with ‘brown eyes’, as illustrated by the interview quote below from Betty, a white recipient with blue eyes:

“You don’t necessarily want to have an extreme, ginger haired brown eyed child born to us which would be a complete mis-match, and the opposite way. ‘How did they have a child that looks nothing like them’ [...] We are both blue [eyes], and I know blue is the recessive gene, but I think if we had a brown eyed child, that would be really different. Green, not a problem or whatever. But to have that would be so different.” [Betty, The Fertility Clinic]

However, because of a shortage of donors, on the whole, these recipients were willing to compromise on this preference and consider accepting donors with a different eye colour and hair colour to themselves (and their partner). Nonetheless, all of the white (female) recipients who were interviewed (and most those that were observed) singled out red hair as a characteristic that they were not willing to accept in a donor. That is, whilst these recipients were willing to accept donors with blond hair or brown hair, regardless of their own hair colour (often one of the two), they were unwilling to accept a donor with red hair, as illustrated by the quote below from Helen:

“Eye Colour, we said any colour. Hair colour, any, although we ruled out red.” [Helen, Creative Fertility]

Recipients’ exclusion of donors with red hair was echoed by observations of recipient consultations and observations of the operation of the recipient waiting list. For example, at Creative Fertility, only 7 recipients were willing to accept a white donor with red hair. This was compared with more than 30 white recipients on the waiting list for a white donor with blond hair or brown hair. Sometimes recipients reinforced

this exclusionary criterion in their informal statements of preferences, e.g. ‘No red hair’. Interviewees’ accounts revealed that they saw red hair as both a kinship risk and, to a lesser extent, as a risk to the social well-being of their child. They therefore sought to exclude this characteristic from their reproduction.

Most recipients described their own hair colour as being “normal” and saw red hair as falling outside of this conceptualisation, e.g. as a deviant characteristic. None of the recipients who were interviewed had red hair themselves. Thus, although recipients did not see hair colour in general as a primary indicator of kinship resemblance, they did see red hair in particular as being a ‘kinship risk’. Unlike other hair colours, recipients stressed that having a child with red hair would “stand out” from their family, leading to others questioning the origins of its hair colour. This view is illustrated by the quote below from Helen:

“So I had ruled out ginger hair, because it’s too different from our family look [...] my daughter is very blond and it would just be those conversations of ‘who does she take after’. Just didn’t want to have them all of the time.” [Helen, Creative Fertility]

Several recipients drew on the example of Prince Harry in the UK having red hair, whilst neither of his parents, Prince Charles or (the late) Princess Diana (his parents), had red hair, which led to his paternity being questioned by the media and general public. In addition to conceptualising red hair as a minority characteristic (which ‘stands out’) some recipients also saw red hair as a stigmatised characteristic and as a risk to their child’s social well-being. Several recipients drew on instances of people with red hair being singled out for negative attention or being bullied on the basis of their hair colour. Thus, despite recipients’ conceptualisation of red hair as an indicator of whiteness they did not see this characteristic as reflecting the *right kind* of whiteness, as illustrated by the quote below from Caroline:

“I don’t know why they [people with red hair] are seen negatively, maybe it’s because of some association with the Scots. It’s strange really, because being ginger shows that you are definitely on the inside, that you are British, but it also means that your child will definitely be bullied at school.” [Caroline, Creative Fertility]

Unlike for white recipients, the importance of eye colour and hair colour rarely featured in BME recipients’ discourses and practices of stating their preferences for BME donors. Instead, BME recipients took the homogeneity of eye colour and hair colour amongst BME communities for granted and therefore did not see these racialised characteristics as an important part of their preferences. In addition to seeing donors’ ethnicity as a proxy for their skin tone, BME recipients also saw ‘ethnicity’ as a primary indicator of donors’ eye colour and hair colour, as illustrated below by the quote from Dipti, an Indian recipient:

“To be honest, when it comes to ethnicities of Asian people, you pretty much get your brown hair, black hair, brown eyes. So that was a given for us.” [Dipti, The Fertility Centre]

Thus, recipients also conceptualised hair colour and eye colour as ‘ethno-racialised markers’ (Hudson and Culley, 2014; Homanen, 2018) which were intertwined with recipients’ conceptualisations of ‘racialised resemblance’.

7.3.3 Socio-Cultural Resemblance

Some recipients also had preferences for donors’ social characteristics, such as their hobbies, attractiveness, and social class. Both clinics allowed recipients to specify their preferences for donors’ social characteristics in their informal preferences. Rarely did recipients specify that they wanted a ‘musical’ donor or an ‘attractive’ donor, as reported in previous studies on egg donation (Nahman, 2006) and sperm

donation (Mamo, 2005; Nordqvist, 2010). On the whole, recipients' preferences for donors' social characteristics related to donors' religion and educational level, which will be explored below.

However, first, it is important to note here that unlike recipients from other ethnic backgrounds, the South Asian recipients (and the Chinese recipient) in this study emphasised the importance of ethnicity as 'cultural heritage'. These South Asian recipients emphasised the importance of their ethnicity to their self-identity in the context of the UK (in which their culture is in the minority). South Asian recipients also conceptualised ethnicity as an important source of socio-cultural resemblance with their donor, and their child (Becker, 2000; Mamo, 2005; Thompson, 2005; Hudson and Culley, 2014). These recipients saw donors' ethnicity as allowing them insight into and familiarity with donors' social backgrounds. This included sharing a similar "Asian element", including upbringing and environment, life values, religion, food, cooking, language, clothes and strong family values (Hudson and Culley, 2014). This view held particular significance for South Asian recipients with a white partner, who didn't share this socio-cultural resemblance with their partner. The quote below from Ayeshah, who had a white husband, illustrates this importance placed on ethnicity as socio-cultural resemblance by Asian recipients:

"For me, the Asian element, it just is my heritage, you know [...] it's a heritage aspect, it's my heritage and therefore I would like my child to know about my heritage [...] so it's those sort of elements. For me, it's just getting a flavour, it's to be aware. That is important. Because the clothes and the food and the culture, it's in our lives, so carrying on that tradition." [Ayeshah, Creative Fertility]

In general, it was not common for recipients to state a preference in relation to the religion of donors, regardless of their own religious identification. Those that did all

identified as being religious themselves and wanted a donor from the same religious background. This was particularly the case for Indian and Pakistani recipients who saw religion as intertwined with their ethnic identity (Culley and Hudson, 2006; Hudson and Culley, 2014). The quote below from Rabiaa, a Pakistani Christian recipient, illustrates this view:

“I wanted a Christian donor, because Christian people are like us. We are Christians. They are not dangerous, they are peaceful, and the donor will be the same.” [Rabiaa, Pakistani Christian, The Fertility Centre]

By far the most common theme to arise from recipients’ preferences for donors’ religion at both clinics was the exclusion of Muslim donors by recipients who were not Muslim themselves. For example, some, mostly Indian Hindu, recipients stated in their written informal preferences: “Not accepting Muslims in any way”. Only 1 couple discussed their exclusion of Muslim donors in any depth. The quote below is from an interview with Amandeep and Inderjit, an Indian Sikh couple, who had declined a donor who was Muslim at a previous clinic.

This couple drew on a range of cultural, genetic and health discourses when justifying their discriminatory exclusion of Muslim donors, including cultural and historical ‘differences’ between ‘Sikhs’ and ‘Muslims’ (Hudson and Culley, 2014) and medicalised and geneticised discourses of the risk of consanguinity in Islamic communities (i.e. reproduction through cousin marriages). Although they did not think a Muslim donor would lead to a visual difference between themselves and their child, they nonetheless strategically depicted Muslim donors as being genetically deviant (Hudson and Culley, 2014) and as a threat to the well-being and health of their child. As illustrated by the quote from this couple below, it was not uncommon for recipients to conflate religion and ‘ethnicity’:

Inderjit: *“I think it’s more the way of life, that habits side of it, Muslims and Indians, the background, the far far background, the way we’re led to believe. How we’re brought up. It’s just what you hear, and what you see going on in the world, you don’t want to be associated with it. It’s not that anybody would know, but it’s in the roots somehow, in the genetics”.*

Amandeep: *“You can’t help but being a bit prejudice. I think it’s to do with our psyche almost [...] and the other thing with Muslim donors is that in some families they have like marrying of the cousins and things like that [...] So it’s not to do with them per se, it’s more that genetic aspect, maybe. I know they [clinicians] check for it, but we had to make sure.”* [The Fertility Centre]

Another social characteristic that was raised as important by recipients was the education/occupation of donors. In the literature on matching, recipients’ preference for an ‘educated donor’ has commonly been depicted as a ‘consumer preference’ of wanting to ‘improve familial qualities (Mamo, 2005). However, in this study, having an ‘educated’ donor (university degree and above) was raised as an ideal and important preference by 10 interviewees, most of whom had a university degree themselves. The majority of these recipients and their partners described education as an indicator of genetically inheritable intelligence and saw having an educated donor as increasing their chances of having an intelligent child. However, they also saw education as an indicator of social opportunity (environment and nurture), which was also regarded as a desirable attribute.

Recipients and their partners were keen to stress that they did not seek to improve the characteristics of their child by having an educated donor. Instead, they stressed the importance of education as an important form of socio-cultural resemblance which helped them to identify with their donor in an otherwise anonymised context. This view is illustrated by the quote below from Betty and Nick:

Betty: *“Because we’re both educated and we both went to university we wanted to have somebody that had that same type of journey in their life, because we want that for our child to be able to possibly have”*

Nick: *“It wasn’t about selecting someone that had higher education because*

of the education. It was about having someone that matches us. We're both university educated, so that would lead us towards it. Now other couples might say they were selecting based on what they want to be, not what they are; but that's not true of us. I want that to be clear. It was about who is most near to you [Betty]." [The Fertility Centre]

7.4 Preference for Donor Information

Having explored recipients' retrospective preferences for donor characteristics, attention will now be paid to recipients' preference for donor information. Clinicians provided recipients with anonymised information about their donor after matching them. The organisation of 'Donor Offering' at each clinic was significantly different, which meant that recipients from each clinic varied in relation to the amount of information they received about their donors (as will be discussed further in Chapter 8). However, regardless of how much donor information recipients were given, most were conflicted about whether they would have liked to have received more information about the donors they were matched with.

On the one hand, recipients saw having some information about their donor as important because it enabled them to decide whether or not to accept donors they were matched with. Some recipients also saw having donor information as "reassuring" because it enabled them to feel a sense of connection with their donor (Becker, 2000). Recipients who wanted more donor information saw this as a source of control, and would have ideally liked more detailed information about their donors' physical appearance and social characteristics, such as a photograph and information about their personality and family upbringing (Becker, 2000). However, these recipients felt conflicted about wanting more information, as illustrated by the quote below from Linda:

"On the one hand I would like to know everything about that person [the

donor], but on the other hand I don't want to know anything!" [Linda, The Fertility Centre]

Indeed, the majority of recipients who were interviewed concluded that they would *not* have liked more information about their donor because they saw this as a 'risk' to the distance they wanted to maintain with their donor. Here, recipients described having more donor information as "uncomfortable", "disturbing" and a "burden" (Rubin et al. 2015). Although some recipients described the amount of donor information they received as "minimal" and "limited" they also concluded that it was "enough".

Recipients saw having "too much" or identifying donor information as a risk to their distance with donors and stressed that they did not want to have "too much connection" or an "intimate relationship" with their donor. In this respect, recipients saw having limited donor as enabling them to manage their own anxieties in the egg donation process and prevent their anonymous donor from becoming "too real". This view is illustrated by the quote below from Dipti:

"They [clinicians] said she's [donor] really nice and lovely and chatty. But then you can't ask for too much. I think that with egg donation you don't want to have too much of a connection, because it's always going to be in your head that I did end up having eggs donated to me. And that's something that I can deal with, but the more and more you find out about the person the more it becomes real to you. Because at the moment it is real to you, but you don't know the person, all they are is on a piece of paper." [Dipti, The Fertility Centre]

The male partners of recipients were particularly keen to emphasise that they did not want more information about donors. These partners raised their own concerns about their role in the egg donation process, and in particular, in reproducing with an anonymous stranger whom they had not met, as illustrated by the quote below from

Roger:

“There’s another angle on this, from my perspective. I think that in a way having less to know about the person, for me, was better. Because you know, I’ve gone through the process now, and touch wood, everything will be fine, we’ll have a lovely baby. But it’s still a big thing for me to get my head around what I’ve actually done. You know, I’ve created a life. I’ve done the most intimate thing you can do with somebody and I’ve got no idea who they are. And in a way I don’t really want to know that much more about them. For me, it’s easier to deal with.” [Roger, Creative Fertility]

Although the majority of recipients and their partners did not want more donor information for themselves, couples who intended to disclose to their child made a distinction between having access to more donor information for themselves and for their child. These interviewees recognised that their child might have curiosity about their donor and want access to information about their “genetic origins”. In this respect, they saw providing their child with more information about their donor as part of their parental duty towards their child, even though they did not want more donor information for themselves. This view is illustrated by the quote below from

Nick:

“It’s important to know the general characteristics, information, enough to feel that that match is correct. But individual specific information would be uncomfortable. There probably should be a legal right for the child to find out about their origins in later life, and that’s good and proper, but I’m not sure that same right should be extended to us at this point in the process. I would be uncomfortable with it.” [Nick, The Fertility Centre]

Regardless of their intention to disclose to their child, recipients were also concerned that having more donor information would make them too critical when selecting donors and therefore lead to delays to their treatment. Recipients were also concerned that if they had more donor information then their desire for more information would be unappeasable (i.e. they would just want more and more). Therefore, most

recipients concluded that whilst more donor information might be appealing, ultimately it was “safer not to know”, as illustrated by the quote below from Inderjit:

“It can help you to have more information about everything, but sometimes the less you know can be better for you as well. Because the more you dig about somebody, their background, and stuff, something will always keep putting you off [...] so sometimes it’s better the less you know, rather than the more you know, because the more you know, the more you’ll want to know. And then you’ll start doubting yourself because you’ve got more to think about.” [Inderjit, The Fertility Centre]

7.5 Conclusion

This chapter focused on recipients’ discourses and practices of stating their preferences for donor characteristics and their perception of donor information within the clinical context of egg donation. Recipients’ accounts revealed that they experienced their infertility and egg donation as stigmatised in society due to going against norms of ‘natural’ and genetic reproduction. As such, recipients sought to reproduce resemblance with their child by selecting a donor who matched their own characteristics with the expectation that these characteristics would be genetically inheritable by their child (and consequently shared with themselves). When conceptualising their preferences for donors’ physical characteristics, recipients foregrounded the role of genetic inheritance and the relationship between resemblance and kinship.

Recipients saw resemblance as a primary indicator of kinship and conceptualised a lack of resemblance as stigmatised and as a ‘kinship risk’, i.e. as a threat to their display of family, potentially revealing of their infertility and as leading to ‘resemblance talk’ (Becker et al., 2005). Recipients were not merely seeking to manage their feeling of stigma ‘by association’ (Neuberg et al. 1994; Goldstein and Johnson, 1997).

Instead, recipients' discourses specifically reflected a 'relational stigma', similar to that experienced by couples in 'inter-racial' (Storrs, 1999; Romano, 2009) and same sex (Frost, 2011) relationships. Here, recipients felt 'relational stigma' by virtue of their relationship with their child rather than because of a direct association with a stigmatised attribute. Recipients sought to manage this stigma by matching a donor with their own characteristics so that their child could 'pass as if' it was their own genetic offspring. In this regard, recipients' preference for resemblance can be interpreted as a form of self-surveillance, in which recipients had little choice but to match for resemblance and replicate a normative ideology of the family. This ideologically constrained preference was further illuminated by the discourses of male same-sex interviewees, who actively chose not to subscribe to heteronormative ideals of reproduction and kinship.

Recipients conceptualised 'ethnicity' as a physical and genetically inheritable characteristic, i.e. as 'race', and as a primary indicator of kinship. Conversely, recipients' conceptualised 'racial difference' as a primary 'kinship risk'. However, recipients differed in their conceptualisation of 'racial' and physical difference and in their willingness to accept donors with different characteristics to their own. Whilst white recipients were unwilling to consider accepting a BME donor, a shortage of BME donors meant that most BME recipients had considered accepting a donor from a different 'racial' background to their own. However, what was most revealing about these differences was recipients' conceptualisation of 'race' in relation to reproduction. Whilst white recipients saw 'racial difference' as a 'discredited stigma' (visible and overt) BME recipients saw 'racial difference' as a 'discreditable stigma' (not immediately obvious), to a degree (Goffman, 1963).

White recipients conceptualised 'race' as inflexible, bounded, and immutable, and could not conceive giving birth to a mixed ethnicity child. These recipients were

concerned about their reproductive legitimacy (e.g. their partner's paternity). Some white British recipients were also unwilling to consider donors from southern European (i.e. 'marked white' donors) because they saw having a child with darker skin tone to themselves as a 'kinship risk'. BME recipients on the other hand could conceive of using a donor from a different 'racial' background and conceptualised 'race' as flexible and could be transgressed, to an extent.

BME recipients could conceptualise having a mixed ethnicity child, although the acceptability of this outcome also reinforced and reproduced a racialised hierarchy of skin tone in which recipients were willing to accept a donor with lighter skin tone than themselves but were unwilling to accept a donor with darker skin tone than themselves. Some black African/Caribbean recipients were more willing to accept a South Asian donor than a white donor. South Asian recipients in particular conceptualised skin tone as both an indicator of kinship and embedded in social norms of desirability and stigma. Although South Asian recipients had considered using a white donor they limited this inclusion to 'marked white' donors, whom they saw as having the potential to 'pass' as Asian. Furthermore, some South Asian recipients were more willing to accept a (marked) white donor with darker skin tone than a South Asian donor with darker skin tone. South Asian recipients' preferences were also shaped by the 'race' of their partner.

Recipients strategically drew on discourses of geneticisation and risk to single out and exclude donors with minority and stigmatised characteristics. Recipients described their own characteristics as being "normal", "average" and socially desirable and framed donors with particular characteristics as falling outside of this conceptualisation. Thus recipients' conceptualisations of 'resemblance' and their conceptualisations of social desirability and stigma were intertwined. Recipients singled out donors with dark skin tone, red hair, a high BMI and who identified as

Muslim for exclusion from their preferences. These characteristics were framed by recipients as being a ‘kinship risk’ and/or a risk to the health and well-being of their child. Thus, the recipients in this study did not directly seek to ‘improve’ the characteristics of their child by selecting donors with desirable characteristics (Mamo, 2005, Burr, 2009) but rather sought to exclude donors who they saw as posing a risk to their child and their family legitimacy.

Despite their emphasis on having a ‘racially matched’ donor, in practice, white recipients and South Asian recipients sought to exclude ‘racially matched’ donors with particular nationalities or geographical ancestry as a way of excluding donors with darker skin tone. This finding echoes previous studies which have reported that recipients sought to exclude donors with darker skin tone from their preferences (Birenbaum-Carmeli and Carmeli, 2002; Nahman, 2006; Schurr, 2016). This chapter also illustrates the ways in which other axis of stigma and discrimination, such as red hair, being ‘overweight’ and identifying as Muslim, are reproduced and reified through recipients’ discriminatory preferences of exclusion.

A recent debate in the literature on gamete donation has been the extent to which recipients would like more information about their donors in the matching process. Typically, access to donor information has been framed in the literature as consumerist and enabling recipients more control, particularly in contexts of donor selection (Becker, 2000, Pennings, 2000). The findings of this study however echo more recent studies in contexts of donor allocation which have highlighted recipients’ desire not to know more information about their donor for themselves (Stuart-Smith et al., 2002; Konrad, 2005; Rubin et al., 2015; Zadeh et al., 2016b) whilst having a desire to know more on behalf of their child.

For example, in a recent study exploring recipients' preference for donor information Rubin et al. (2015) referred to the negative consequences of providing recipients with more information as a 'paradox of choice' whereby more information was seen as a source of more control and as a burden, and reflects "the ways in which having options undermined, rather than enhanced, the process of choosing" (314). In this study, recipients appeared to face a paradox of conflicting identities. On the one hand, reflecting a consumer identity, recipients wanted more information about their donors to use as a donor selection tool (for control). On the other hand, recipients saw having "too much" donor information as a risk to their own identity as parents and the distance they wanted to maintain with anonymous donors. However, recipients saw having more and identifying donor information as their child's 'right', and in this respect, saw having access to more donor information in the future as part of their parental obligation towards their child.

Konrad (2005: 183) described recipients' desire not to know more as "active not-knowing", which she argued was a mechanism for recipients to construct relatedness with their child by displacing the role of the donor. This reflects another tension in the literature, whereby some researchers have argued that recipients "obliterated" the role of their donor when seeking to construct kinship and resemblance with their child (Edwards and Strathern, 2000; Murray and Golombok, 2003; Konrad, 2005; Nordqvist, 2010; Braverman and Frith 2014) whilst other researchers have argued that recipients "re-materialized" their donor and in order to construct kinship with their child (Mamo, 2005: 246; Klotz, 2014). In the context of sperm donation, Grace et al. (2008) have also highlighted how recipients can hold multiple and ambiguous conceptualisations of donors, as both 'present' and 'absent' (Grace et al., 2008).

Neither of these extremes represented the experience of recipients in this study. Instead, interviewees in this study appeared to conceptualise donors in a liminal role,

where on the one hand they sought to maintain distance between themselves and their donor (i.e. avoid their donor becoming ‘too real’) whilst on the other hand they did not want to completely deny the existence of their donor as a person. Having presented recipients’ preferences for donor characteristics and recipients’ perceptions of donor information, the following chapter will explore recipients’ practices of selecting donors that they were matched with. This will include exploring how recipients’ preferences, amongst other factors, shaped their practices of accepting and declining donors.

Chapter 8: Recipients' Practices of Accepting and Declining Donors

8.1 Introduction

In the previous chapter recipients' preferences for donor characteristics were explored, illustrating how they foregrounded notions of genetic inheritance and resemblance as an indicator of kinship. In this chapter, recipients' practices of accepting and declining donor they were allocated be explored, including how recipients interpreted and utilised the donor information they received. This will include exploring the impact of contextual constraints, such as the organisation of the matching process in each clinic and recipients' perceptions of clinicians, as well as examining the discourses recipients drew on when discussing their acceptance or refusal of donors.

Previous studies which have explored recipients' preferences for donor characteristics and practices of selecting donors have often conflated the two, or have not reported on these two stages separately (Birenbaum-Carmeli and Carmeli, 2002; Mamo, 2005; Nahman, 2006, Nordqvist, 2010; Whitaker and Speirer 2010, Homanen, 2018). This is particularly the case for studies which have taken place in contexts of sperm donor selection, where researchers have emphasised recipients' agency in selecting donors. Few studies have explored the constraints shaping recipients' practices of accepting/declining donors in contexts of donor allocation or to what extent recipients were willing to compromise on their original preferences for donor characteristics.

In the USA, Lindheim and Sauer (1998) reported quantitative findings in which they compared recipients' preferences for donor characteristics with their practices of selecting donors. The researchers' post-hoc reviewed 80 matches over a period of 16

months and found that 71% of recipients had accepted the first donor offered to them and 29% declined. Whilst studies in the UK context have alluded to constraints shaping recipients' practices they have not explored recipients' perceptions and negotiations of these in any depth (Konrad, 2005; Braverman and Frith, 2014; Klotz, 2014; Zadeh et al., 2016a). The focus of this chapter will not be on how recipients construct kinship with their child but on recipients' material practices of accepting and declining the donors they were offered, which is part of a larger matching process (e.g. stating preferences and being allocated a donor). However, recipients' conceptualisations of kinship will be explored in so far as this influenced their preferences and practices of donor selection.

To begin with, recipients' practices of *declining* donors will be presented with a focus on the most common characteristics by which donors were declined. Attention will then be given to recipients' practices of *accepting* donors, and in particular donors with different characteristics to their own. Finally, the *different rates* at which recipients accepted and declined donors at the two clinics in this study will be explored, followed by recipients' perceptions of clinicians and the matching process at each clinic.

8.2 Declining Donors: Marginalised and Stigmatised Characteristics

In the previous chapter on recipients' preferences the characteristics that recipients did not want in their donor were explored. In this section attention will specifically be given to the donors that recipients were matched with and declined, and the characteristics by which donors were most commonly declined.

In the literature on donor selection, some researchers have reported the characteristics that recipients did not want to accept in their donor (Nahman, 2006; Kroløkke 2014;

Berman, 2015), but few have reported recipients' practices of declining donors (Lindheim and Sauer, 1998; Thompson, 2009). Lindheim and Sauer (1998) reported that recipients were just as likely to accept a donor regardless of how long they had been waiting for a match and that, consistent with their original preferences, recipients' declined donors on the basis of a range of characteristics, including weight, height, skin tone, education and health. However, no more than 2 recipients declined (presumably different) donors on the basis of possessing these characteristics.

The data drawn upon in this section are predominantly taken from Creative Fertility, where the majority of recipients declined donors; this includes observations of 152 matches at Creative Fertility, including 81 recipients and 65 donors, observations of 'Donor Offering Consultations' at The Fertility Centre and interviews with recipients who excluded donors at both clinics. At The Fertility Centre it was *less* common for recipients to decline donors than at Creative Fertility, although when choosing between multiple offered donors recipients exclusion of donors with particular characteristics was clear. Importantly, although recipients declined donors at different rates at each clinic (as will be explored further below) their reasons for declining donors were similar across both clinics.

It is useful to note here that the donors that recipients were matched with *should* already have been filtered through the preferences that they stated at their clinic. However, this was not always the case, e.g. as explored in Chapter 6 clinicians prioritised their own matching criteria over recipients' preferences. Furthermore, although recipients may have been willing to accept donors with certain characteristics in theory (in their preferences) they may have not been unwilling to accept them in practice (when offered a donor).

Recipients declined donors for a range of reasons and on the basis of a variety of (and often multiple) characteristics. For example, sometimes recipients declined donors because: they thought a donor was ‘too old’; the donor was a carrier of a genetic condition; they wanted a donor who was a “closer match” in physical characteristics; or they were not ready to start treatment. More commonly, recipients declined donors on the basis of possessing particular characteristics, which were usually different to recipients’ own. The meaning that recipients attached to these characteristics were explored in the previous chapter and so will not be explored here. Here, the main aim is to illustrate the systematic nature by which donors with particular characteristics were excluded from donating by multiple recipients.

The main characteristics by which interviewees declined donors will be outlined below. It is important to note here that in practice many recipients declined donors on the basis of possessing multiple ‘undesirable’ characteristics. However, these characteristics have been separated for heuristic purposes. Firstly quantitative data gathered from observations will be reported followed by data from interviewees. Descriptive analysis of 152 matches at Creative Fertility revealed that the majority of donors (74%, n=48 out of 65) were declined by at least once. However, some donors were declined more than others (between 1-6 times by different recipients). Whilst the majority of donors were declined by one or two recipients (82%, n=39 donors), 9 donors (18%) were declined by at three recipients or more; that is, they were the most declined donors in the clinic. The characteristics by which recipients most commonly declined donors were: being ‘overweight’, having red hair, identifying as a lesbian and having no higher education degree.

The number of times that these 9 individual donors were declined and the reasons recipients often gave for declining them are outlined in Table 8.1 below.

Table 8.1 Donors Declined 3 Times or More by Recipients at Creative Fertility over 10 Months Period of Observations from 152 Matches

Number of Times Donor Declined	Number of Donors	Recipients' Reason(s) for Declining Donors
6	1	Red Hair
5	2	'Overweight'
4	1	'Overweight'
3	5	Multiple Reasons per Donor: Lesbian, Marked White, 'Overweight', No University Degree
	Total=9	

As illustrated by the table above, the single most frequently declined *donor* at Creative Fertility was a donor with red hair. This donor was declined by 6 different recipients before being accepted (over a 4 month period of observations). One might recall from Chapter 7 that only seven recipients were willing to accept this donor in their stated preferences. The most commonly declined *characteristic* in donors was weight, or rather being 'overweight'. Two donors were declined by 5 recipients each and 1 donor was declined by 4 recipients because they had a high BMI; these 3 donors alone thus made up for 14 of the declined matches in the clinic. Each of these donors had a high BMI (28-30) and would have been classed as clinically obese (although they met the clinic's screening criteria for donors).

Five donors were declined by 3 recipients each. Recipients gave multiple reasons for declining these donors. For example, one donor was declined by multiple recipients because she identified as a lesbian and had no university degree, one donor was declined because she was Bulgarian ('marked white') and had a high BMI, and

another white British donor was declined because she was ‘marked’ as being ‘born in Mexico’ and had no university degree.

Although not apparent from the table above, the declining of ‘marked white’ donors was not an uncommon occurrence, particularly by white British recipients. At least 2 recipients declined donors, at least in part, because they were Portuguese, Columbian, Latvian or Romanian. Several white British recipients also declined ‘marked white’ *British* donors on the basis of their ‘markedness’ (i.e. additionally labelled characteristics); one donor had a “Maltese grandmother” and the other donor was “born in Mexico” (as stated on their profiles). In the former case, recipients appeared to foreground the donor’s genetic ancestry over her white British nationality whilst in the latter case recipients appeared to prioritise the donor’s place of birth over her white British genetic ancestry. In each case, recipients strategically naturalised different aspects of donors’ identity in defining them as not being the ‘right kind’ of white donor, as found in transnational studies of egg donation (Bergmann, 2015; Schurr, 2016; Homanen, 2018).

Data from interviewees’ accounts of declining donors echoed the findings from observational data. Interviewees also declined donors for a range of reasons, including eye colour, health and age. Table 8.2 below outlines the *main* characteristics by which interviewees declined donors and the number of recipients who declined donors on the basis of possessing these characteristics.

Table 8.2 Interviewees Main Reasons for Declining Donors Across Both Clinics

Main Characteristics by which Donors were Declined	Number of Recipients	Clinic
'Overweight'	4	Creative Fertility
Red Hair	2	Creative Fertility
Lack of Education/Occupation	2	Creative Fertility
Lesbian	2	The Fertility Centre

Most of these characteristics were coherent with the characteristics that recipients sought to exclude in donors when stating their preferences for donor characteristics (as explored in Chapter 7). Although recipients seldom specified a preference for donors' sexuality some recipients declined donors for this reason. When discussing their reason for refusing lesbian donors couples often drew on similar discriminatory discourses couples who sought to exclude Muslim donors from their preferences (as explored in Chapter 7).

What was especially illuminating about interviewees' accounts of excluding lesbian donors was their re-negotiation of their original preferences and their apparent prioritisation of social characteristics over 'race'. That is, two interviewees declined lesbian donors even though these were the only donors available who met their 'racial preferences'; one recipient was Indian and declined an Indian donor and the other recipient was Iranian and declined a white British donor. When declining donors, recipients foregrounded donors' 'undesirable characteristics' (e.g. sexuality) over their 'desirable' characteristics (e.g. 'race'). They also foregrounded the criteria they wanted to exclude in their donor (from their preferences) over delays to their treatment, as illustrated by the quote below from Betty, who declined a donor based

on eye colour. In this respect, the characteristics by which donors were declined became their ‘Master Status’ (Hughes, 1945) in recipients’ eyes.

“We’re not just going to take any person. We would love to have a family, but we are not just going to take anything. That was the whole point of why we’re going through this [...] So we took the hard choice to say ‘no’ we’re going to wait.” [Betty, The Fertility Centre]

Recipients’ motivation for excluding donors with red hair, a high BMI, no education and marked white ethnicity/skin tone were explored in Chapter 7 and so will not be repeated here. Of note here is that recipients excluded donors with these characteristics from both their *preferences* and *practices* of selecting donors. This meant that donors with these characteristics could only be offered to a small number of recipients (who were willing to accept them) and that those recipients who they were offered to often declined them. Furthermore, donors who possessed multiple ‘undesirable’ characteristics were less likely to be accepted by recipients.

In previous studies, researchers have generally framed the exclusion of donors with undesirable characteristics as isolated incidents (Lindheim and Sauer, 1998; Klotz, 2014). However, the collection of data through multiple methods and analysis through angles of enquiry enabled insight into recipients’ patterns of excluding donors and revealed that the exclusion of donors with particular stigmatised/marginalised characteristics was systematic i.e. they were excluded from recipients’ preferences and were declined by at least 3 recipients. This included donors with red hair, a high BMI, dark skin tone, and who identified as Muslim or lesbian.

Despite having been accepted by the clinic, donors with these characteristics waited much longer to donate than other donors (as they were offered to different recipients over a period of several months). On some occasions they were prevented from donating at all. For example, at Creative Fertility a donor with red hair was declined

so many times that she left the clinic before donating and on another occasion a donor from Bulgaria left the clinic because she had been declined by multiple recipients and her student visa ran out. At The Fertility Centre, recipients' exclusion of 'overweight' donors led to the clinic freezing the eggs of these donors (before they left the clinic without donating) and screening out donors with a high (but 'acceptable') BMI range from the outset. Thus the reproduction of donors with marginalised/stigmatised characteristics was stratified, whereby it was devalued and avoided by recipients and discouraged from being reproduced.

As shown above, recipients were unwilling to compromise on their preferences of exclusion and accept donors with different (and marginalised) characteristics to their own. However, this was not the case for all types of differences. When accepting donors recipients drew on a different set of discourses to legitimise accepting donors with different characteristics to their own.

8.3 Accepting Donors: Accepting Difference

In previous studies on recipients' selection of gamete donors it has generally been assumed that recipients selected donors according to their preferences for donor characteristics and that this selection is a consumer practice (Becker, 2000; Fogg-Davis, 2001; Pennings, 2000; Birenbaum-Carmeli and Carmeli, 2002; Konrad, 2005; Mamo, 2005; Nahman, 2006; Costa, 2007; Nordqvist, 2010; Whitakker and Speier, 2010; Kroløkke, 2014; Deomampo, 2016, Schurr, 2016; Homanen, 2018). Researchers have also focused on how recipients constructed resemblance with the donors they selected as a mechanism to construct kinship relatedness with their child (Becker 2000; Konrad, 2005; Thompson, 2005; Klotz, 2014; Bergman, 2015).

As such, these studies have argued that recipients' selection of donors is a consumer practice and a kinship practice, embedded in discourses of genetic inheritance (Becker 2000; Mamo, 2005; Szkupinski-Quiroga, 2007). However, most of these studies have conflated recipients' preferences for donor characteristics and their practices of selecting donors, particularly in contexts of donor selection, and have seldom explored whether recipients' practices were coherent with their preferences – and how recipients negotiated any gaps between them. Whilst these studies have alluded to the constraints on recipients' practices of selecting donors there has been little in-depth exploration of recipients' perceptions of these constraints and how they negotiated them. In particular, missing from previous studies is how recipients rationalised accepting donors with different characteristics to their own.

In this study, all the recipients who were interviewed (eventually) accepted a donor that they were matched with (n=18). These recipients accepted a donor who matched their own ethnic/'racial' background (apart from one Indian recipient). However, the majority of recipients felt that their other preferences for donor characteristics were not met in the donor they accepted. Despite recipients' emphasis on having physical resemblance with their donor, in practice, recipients spoke more about the physical differences between themselves and the donor they accepted than the physical resemblance they shared. Thus, the process of accepting a donor, for the recipients in this study, appeared to be more about negotiating and rationalising physical difference between themselves and their donor/child than it was about constructing physical resemblance.

Central to recipients' discourses of accepting difference in their donor was the constraints shaping their practices. The theme of 'compromise' was central to recipients' discourses of accepting donors, as illustrated by the quote below from Nick, the partner of a female recipient:

“The whole process is about compromise, and how far are you willing to compromise. So for each couple I’m sure the different characteristics are weighed in different ways. So certain aspects will be more or less important to them.” [Nick, The Fertility Centre]

When rationalising the difference they accepted in their donor, recipients’ discourses revealed the constraints shaping their practices as well as nuanced forms of recipient agency. Recipients foregrounded the importance of contextual constraints in rationalising their compromises but they also employed rationalising discourses to strategically minimise, legitimise, naturalise and override difference with their donor/child in order to accept their donor. This included foregrounding the importance of time and donor shortages and drawing on: fatalistic discourses, the presence and absence of resemblance within families and the construction of socio-cultural resemblance. Interestingly, at The Fertility Centre, recipients also foregrounded their trust in clinicians when discussing why they accepted difference with their donor (explored further below in Section 8.4).

8.3.1 Foregrounding Contextual Constraints

All of the recipients in this study reported that time and a shortage of donors were strong determining factors in their acceptance of donors, and in particular, their acceptance of difference in their donors. Recipients foregrounded these constraints as necessitating that they compromise on their preferences and accept donors with different characteristics to their own. Many recipients had been trying to conceive for a long time before deciding to use egg donation and emphasised that they didn’t want to delay having a child any longer. Several recipients commented that if they felt they had more time they would have been more discerning about the characteristics they

accepted in their donor. The quote below from Tina illustrates how recipients compromised on the characteristics they accepted in their donor because of time:

“First I was adamant, green eyes or blue eyes, but it’s got to the stage that the donor that we are using has hazel eyes. Because we could’ve gone on for months and months waiting, until someone else came along, and we don’t have time on our side [...] So you become a little bit more relaxed about the process, about your criteria.” [Tina, The Fertility Centre]

The age of recipients was also a factor in recipients’ perception of time. The majority of interviewees were over the age of 40 and had social and medical concerns in relation to being an “older mother”. These recipients were especially concerned about their ‘treatment clock’ in that after the age of 50 they would be excluded from having treatment in the clinics. The quote below from Camille illustrates recipients’ concerns about their age in shaping their acceptance of their donor:

“I couldn’t wait ages, you know. It was already 8/9 months and I was going to become 47, for me this is the limit, I already struggled and hesitated a lot about my age, and giving birth at my age and so on. So I thought a lot about it. So I decided to do it. But I know I’m an old mother. I don’t want to push that anymore. So it had to happen.” [Camille, Creative Fertility]

Of note here is that whilst time was an important feature in recipients’ discourses of accepting donors at both clinics, it was raised as the main reason for accepting donors at Creative Fertility. Recipients at Creative Fertility waited longer to be matched with a donor than recipients at The Fertility Centre and typically declined donors before accepting a donor, thus leading to further delays to their treatment. Having declined one or more donors already, recipients felt that there were only so many donors that they could decline without affecting their position on the waiting list, as illustrated by the quote below from Brenda who had declined a donor before accepting her donor:

“I just felt like there’s only so many times you’re gonna be presented with someone and say no without feeling like, am I just going further down the list or is it going to be months and months.” [Brenda, Creative Fertility]

Inherent in recipients’ discourses of accepting donors because of time was the relatively low supply of donors at each clinic, which meant that they had to wait to be matched with a donor. All of the recipients spoke about a shortage of donors as necessitating that they compromised on their preferences for donor characteristics. Recipients were also aware that a shortage of donors entailed a shortage of donors with a particular mix of characteristics, such as the recipients’ own. Thus recipients saw a shortage of donors as constraining their choice of a donor, as described by Betty:

“I’d like to have more choice, but I know there’s not that many donors who come along. But it would be nice to pick more characteristics that are completely what we want. But we know we’re not necessarily going to have that.” [Betty, The Fertility Centre]

A shortage of donors was particularly evident in BME recipients’ discourses of accepting donors. Unlike the white recipients who were interviewed BME recipients often cited the ethnicity of their donor as their main reason for accepting her. This reason was given regardless of whether the donor matched the recipients’ own specific ethnic background. Central to BME recipients’ discourse was that a shortage of BME donors meant they had little choice but to accept the BME donor that they were offered. BME recipients thus saw their agency in donor selection as being inherently constrained by their own ethnicity, as illustrated by the quote below from Jonathan, the (white) partner of a Chinese recipient, who accepted a Chinese donor:

“It’s difficult, as I say, you’ve got a choice of one or two really, and physical height and weight don’t come into it. So that was really the choice we had. As far as choosing an egg donor, it’s very much not a lot of choice. There’s not a

lot of free choice in it at the moment. So we really take what we can get.”
[Jonathan, The Fertility Centre]

8.3.2 Fatalistic Discourses

When rationalising why they compromised on their preference for resemblance, recipients commonly drew on fatalistic discourses to rationalise accepting a donor with different characteristics to their own. As depicted in the healthcare literature on patients' healthcare behaviour, recipients used this phrase as a way of managing their uncertainty, recognising their lack of control, and to re-negotiate their preferences for resemblance (Keeley et al., 2009). Some recipients drew on notions of 'fate' or 'destiny' to justify why they accepted their donor. More commonly, recipients utilised the fatalistic phrase, 'at the end of the day', accompanied by a rationalisation for the compromises made. For example, recipients qualified differences with their donor by emphasising that 'at the end of the day' all that all that mattered was having a 'healthy baby', as illustrated by the quote below:

“The one thing I can tell you is I'm quite tall and my husband's quite tall [...] And then, I'll be honest with you, we saw her height and she's just above 5 foot, so for a few days we were like 'oh no', and I was like 'oh no' [...] Like I said, it was just the height, will it look, you know... in terms of our children`. And then we thought that doesn't matter, at the end of the day as long as our child is healthy and happy that's our child.” [Ayeshah, Creative Fertility]

Recipients used a range of such rationalisations to accept difference with their donor, including describing their donors' characteristics as “close enough” to their own; concluding that their donors 'good characteristics outweighed the bad' or reasoning that they 'could not control everything', as illustrated by the quote below from Camille:

“She had brown eyes, not what I would've liked. But you have to compromise. It was not the ideal thing in all terms, but overall, the good characteristics for

me much more outweighed the not so perfect ones. And overall I felt it was fine. I could live with a child with brown eyes, and taller than me. She's 10cm taller, so she's really tall. So yeah, I would've preferred smaller somehow, but this is all so material and conjectural somehow, in the end, it doesn't really matter I think. You cannot control everything [...] you have to give up on everything being fine." [Camille, Creative Fertility]

It was also common for recipients to accept donors with different characteristics by reasoning that they had to "let go" of their child resembling them and accept that their child will be 'whoever they turn out to be'. In this respect, recipients might be interpreted as de-emphasising the role of the donor by highlighting the role of fate in determining the characteristics of their child:

"I think at some point you'd need to let go and just go 'this will be, our baby will be our baby, and our baby will be who they are'" [Brenda, Creative Fertility]

8.3.3 The Presence and Absence of Kinship Resemblance

Another rationalisation that was drawn upon by recipients to legitimise accepting donors with different characteristics to their own was to strategically draw on a discourse of either the presence or absence of resemblance within their own immediate and wider families. This also involved recipients drawing on different genetic discourses to rationalise their decision-making.

When drawing the absence of resemblance between members of their immediate family recipients disentangled the normative relationship between kinship and resemblance by drawing on a lack of resemblance between genetically related family members. Here, recipients drew on a discourse of 'genetic unpredictability' to legitimise difference between themselves and their child (and between themselves and

their donor) by drawing on a range of differences, such as eye colour, hair colour, personality and educational attainment, between members of their family. For example, Uzma, a recipient with 3 existing children from a previous relationship, expressed this as follows:

“My daughter looks like me, but my sons don’t look like me. ‘Cause I’ve got a son, 2 sons, one’s really chubby, and one’s really tall and skinny. So there’s a lot of difference between them two. So, you can’t say that you want a donor that’s going to look like me. You can’t say if that child’s gonna look like you or not. That’s what I believe in. Not that the donor has to look exactly like me”
[Uzma, The Fertility Centre]

Conversely, recipients also strategically drew on the *presence* of particular characteristics (possessed by their donor but different to their own) within their wider family. Unlike the previous strategy, where recipients emphasised the absence of resemblance between genetically related family members, here recipients sought to normalise difference by overtly relying on the relationship between kinship and resemblance, and the genes mediating this relationship (Szkupinski-Quiroga, 2007). For example, one recipient with blue eyes accepted a donor with brown eyes, reasoning that her sister had brown eyes. Another recipient accepted a donor who was taller than her on the basis that her own mother was taller than her.

This strategy enabled recipients to provide some justification for their child having different characteristics to their own. In doing so, recipients could lay claim to possessing the genes for different characteristics (albeit in latent form) by virtue of sharing a similar gene pool to their family members with these characteristics. This strategy relied on a discourse of ‘latent geneticisation’ as opposed to ‘genetic unpredictability’. Unlike white and black recipients, the South Asian recipients in this study also used this rationalisation when accepting a donor with a different ‘race’ to themselves.

In the previous chapter on recipients' preferences, we saw how Amandeep had considered using a white donor on the reasoning that her Indian niece "looked white". In practice, Amandeep was offered and hesitantly accepted a Sri Lankan donor, despite her concerns about the donor having dark skin tone (which she associated with the donor's ethnicity). In justifying why it was reasonable to have a child and accept a donor with darker skin tone than herself Amandeep drew on the presence of dark skin, or rather a "dark gene", in her wider genetic family:

"But even then, because one of my cousins, he's got 3 daughters and the middle one is very very dark. But she is definitely his daughter [...] The reason is, we think, she's got some sort of black gene [...] Because on my dad's side there is a dark gene there. So it doesn't matter, even if it [the child] was darker, in the bigger scheme of things we'd just accept it. It's not the end of the world." [Amandeep, The Fertility Centre]

Interestingly, such rationalising discourses were not equally applied by recipients to legitimise accepting all types of differences. For example, several recipients referred to members of their family, or their partner, being overweight or having red hair. However, these characteristics were seen by recipients as posing a risk to their child's well-being or to their display of kinship and so could not be mediated. That is, they were seen as being "too different" to themselves, as illustrated by the quote below from Brenda:

"I mean I've got members of the family with red hair, so it's feasible that we could have a red haired baby anyway. But we just thought stick to as close to me without being too restrictive." [Brenda, Creative Fertility]

Recipients also drew on a particular discourse of unilateral genetic inheritance (i.e. through one parent, the father), rather than on scientific notions of bilateral descent, to accept difference in their donor. Here, couples foregrounded the role of recipients' partners' genes in determining the characteristics that their child might inherit. This

discourse allowed recipients to negate the role of their donor, including difference with their donor, by foregrounding the genes of their partner (the baby's father), as illustrated by the quote below:

"I'm thinking 50% at least surely. I know it's not always, some of the time they look just like their mum, but a lot of the time you do get the paternal side stronger." [Amandeep, The Fertility Centre]

Couples frequently emphasised the "strong", "dominant" and "defining" physical characteristic of recipients' partners, such as a particular shaped nose or chin, being "tall" or having "blue eyes", which they described as being symbolic of a wider "family look" (e.g. shared by his parents and siblings). This conceptualisation allowed couples to imagine recipients' partners having 'strong and dominant genes' which they hoped would be inherited by their child over and above donors' characteristics (especially where these were different from the recipient). The quote below illustrates how couples foregrounded the genes of the father over their donor in determining their child's physical appearance:

"I think with me, looking at my family, going back up to my granddad, there are very strong characteristics, There's like a Johnson nose that myself, my brother and sister have. We all have dad's eyes. We don't have my mum's eyes [...] There's the Johnson chin. So I can imagine, probably, those would be quite strong characteristics that come through in our baby." [Roger Johnson, Creative Fertility]

Couples did not use this discourse to directly negate difference between recipients and their child. Rather, it allowed them to imagine their donors' different characteristics (and genes) as being recessive compared with those of recipients' partners. In a minority of cases at each clinic recipients sought to match donors' characteristics to their husband instead of themselves (where these were different). This strategy seemed to be employed by recipients to facilitate the likelihood that their child would

resemble at least one parent (i.e. the father) and to minimise the risk that their child would inherit different characteristics not possessed by either parent (i.e. ‘resembling the donor’).

Thus some recipients sought to match donors’ characteristics with those of their partner, over their own, as a strategy for containing difference within the family. This practice allowed recipients to theoretically hide their donor’s genetic contribution to their child, or rather, to make it theoretically indistinguishable from their husbands’ genetic contribution. In turn, this allowed recipients to legitimise physical difference between themselves and their child (and to rationalise accepting a donor with different characteristics to themselves).

8.3.4 Constructing Socio-Cultural Resemblance

Another strategy that recipients used for accepting their donor was to construct socio-cultural resemblance between themselves and their donor based on the donor information they were given about donors (verbally and in written form).

Unlike the strategic discourses of rationalisation outlined above, which were used to specifically negate physical difference between recipients and their child, here recipients strategically constructed socio-cultural connections with their donor as a mechanism of identifying with her and making her less of a “stranger”. For some recipients, this process of identification was an important element of accepting a donor. Not all of the recipients who compromised on their preferences drew socio-cultural connections with their donor. However, all of the recipients who constructed these cultural connections had compromised on their preferences. Furthermore, only the middle-class recipients (from all ethnic backgrounds) constructed these social connections.

These recipients described their donors as being “familiar”, sharing a “connection”, coming from the “same surroundings”, sharing a “similar world” and doing the “same kind of stuff” as themselves. Recipients typically drew on shared hobbies (travelling, painting, photography, hiking, cycling and acting), occupation, lifestyle, upbringing, socio-economic background, country of origin, education and ethnicity (for BME recipients). Recipients not only drew these connections with themselves, but also between donors and their partner. Several recipients described the socio-cultural resemblance they shared with donors as being the “cherry on the cake”, a “bonus” and “reassuring” when selecting their donor, rather than the primary reason for accepting her. Recipients’ construction of socio-cultural resemblance with their donor is illustrated by the quote below from Camille:

“Well the nurse did tell us a bit about her background. She quite liked nature, and it's the case for us too. She loved bicycles, and my husband, he loves cycling and repairing and things. It was the cherry on the cake, not the thing that made you decide. But I was feeling it [...] I think she doesn't come from too far surroundings, the type of social and cultural ... where she comes from, the background, so in the end she doesn't seem too far from where me and my husband come from. It seems quite close.” [Camille, Creative Fertility]

In this context, religion and ethnicity were also seen as an important source of connection for most BME recipients, who saw donors with these same characteristics as themselves as being ‘trustworthy’ and ‘familiar’ (as seen in Chapter 7 on recipients’ preferences for donors’ social characteristics). Most recipients also drew on cultural connections between themselves and their donors’ country of origin (where this was outside of the UK), as illustrated by the quote below from Linda, a white German recipient, who accepted a donor from Estonia.

“She's [donor] from Estonia. And just this year we went to Latvia, which is just outside of Estonia. Because we've got friends who live there, so I can kind of associate myself with that area as well, very strong minded. There's lots of German influence up there as well. And the way her personality was

described, I could identify myself more with it. I think that made it an even easier decision." [Linda, The Fertility Centre]

Thus recipients' construction of socio-cultural resemblance enabled them to identify with their donor which was a step in the process of accepting their donor. Previous studies have also highlighted the ways in which recipients of gamete donation use donor information to construct socio-cultural resemblance. Drawing on a framework of kinship studies researchers have argued that recipients constructed socio-cultural resemblance with their donor as a "kinship device", to construct kinship "connexions" (Konrad, 2005: 46) and "affinity ties" (Mamo, 2005: 248) with their child. These researchers have argued that recipients geneticised their donors' social characteristics and treated them "as if" they were genetically inheritable by their child and shared with the recipient.

In this study, the primary question of interest was how recipients accepted the donors that they were matched with. In this context, recipients' construction of socio-cultural resemblance with their donor appeared to be a mechanism by which recipients could identify with their donors so that they could accept them. In the context of (temporary) donor anonymity such social connections made donors less strange and more familiar to recipients thus helping them to overcome the differences between them.

8.4 The Impact of Context on Recipients' Practices

As discussed above, although all of the recipients in this study accepted a donor they were matched with before doing so some recipients declined donors. A key finding here was the difference between in recipients' rates of declining donors at each clinic, which was evident from interviewees' accounts and ethnographic observations. At

Creative Fertility, the majority of recipients declined the first donor they were offered whilst at The Fertility Centre the majority of recipients accepted the first donor they were offered.

Below, data on recipients' rates of accepting and declining donors at each clinic will be presented. In order to provide some explanation for this difference, recipients' perceptions of clinicians and the matching process at each clinic will be presented alongside ethnographic data relating to the organisation of matching in each clinic

8.4.1 Rates of Accepting and Declining Donors

At Creative Fertility, where recipients were offered a single donor at a time, the majority of recipients who were interviewed declined donors that they were matched with; 5 out of 7 interviewees declined at least one donor (between 1-4 donors) and only 2 interviewees accepted the first donor who was offered to them. At The Fertility Centre, where recipients could be offered multiple donors at a time, the majority of recipients accepted (one of) the first donor(s) they were offered; here, 9 out of 11 interviewees accepted a donor without declining and only 2 recipient declined donors. Table 8.3 below summarises the number of donors declined at each clinic

:

Table 8.3 Number of Interviewees who Accepted or Declined First Donor Offered at Both Clinics

	Creative Fertility	The Fertility Centre
Accepted First Donor	2	9
Declined at least one Donor	5	2
Total Number Interviewees	7	11

Interviewees' patterns of accepting and declining donors were echoed by ethnographic observations of recipients' practices. At Creative Fertility, 152 matches were made by clinicians over the 10 month period of observations which comprised 81 recipients and 65 donors, many of whom were matched more than once. Of the 81 recipients who were matched, 74% (n=60) declined at least one donor whilst only 26% (n=21) accepted the first donor they were allocated, as illustrated by Table 8.4 below. Conversely, this meant that of the 65 donors who were matched at Creative Fertility, 74% (n=48) were declined at least once. The characteristics by which these donors were most commonly declined were discussed at the beginning of this chapter (Section 8.2).

Table 8.4 Number and Percentage of Recipients Who Declined or Accepted a Donor at Creative Fertility over 10 Months of Observations

	Number	Percentage
Accepted First Donor	21	26%
Declined at Least One Donor	60	74%
Total Number of Recipients Matched	81	100%

At The Fertility Centre, it was not possible to systematically record the number of recipients who declined donors (as this information was not recorded by the clinic). However, ethnographic observations generally echoed interviewees' practices, where the majority of recipients accepted one of the first donors they were offered. For example, of the 15 'Donor Offering' consultations which were observed only 2 recipients declined a donor over a telephone consultation. It is important to note here that whilst the rate at which recipients declined donors was different at each clinic, on

the whole, recipients' reasons for declining donors across both clinics were similar (and will be explored in the last section of this chapter).

8.4.2 Recipients' Perceptions of Clinicians and the Matching Process

Researchers have reported that the role of context is of central importance to medicalisation and stratification (Singer, 1989; Massey, 2007; Kaplan et al., 2010) and have stressed the importance of "trust" in patient decision-making in ARTs and healthcare more generally (Mechanic, 1996; Lupton, 1997; Lee and Yin, 2011; Hall et al., 2001; Mechanic and Meyer, 2000) few studies have touched on the impact of recipients' trust, or lack of trust, on their practices of selecting donors. In the UK context of egg donation, Klotz (2014) reported that sometimes recipients challenged clinicians' authority in matching by declining donors.

On the other hand, Konrad (2005) reported that the recipients in her study were rarely critical about clinicians or the matching process and did not decline donors for fear of seeming 'too demanding', 'ungrateful' or 'jeopardising' their place in the long waiting list for donors. In this respect, Konrad (2005) argued that although "the American system exacts a price, and can be criticised for its market-driven profiteering, these examples from Britain show how 'hidden costs' are built into the system as polite fictions" (ibid: 150). However, none of these UK ethnographies considered the impact of recipients' trust in clinicians on their practices of selecting donors. Nor did they explore recipients' practices of accepting and declining donors in any depth.

In this study, recipients' discourses revealed that donors' characteristics were not the only factor shaping their decision to accept or decline donors. Instead, context appeared to be a significant factor in recipients' decision-making, in particular,

recipients' trust in clinicians and, relatedly, their perception of the matching process. More specifically, at Creative Fertility, where the majority of recipients declined the first donor they were matched with, a lack of trust in clinicians and questioning of the matching were dominant features of recipients' discourses of declining donors. At The Fertility Centre on the other hand, where the majority of recipients accepted the first donor they were matched with, recipients' trust in clinicians was a central feature of their discourses of accepting donors. These factors will now be explored in relation to each clinic individually.

Creative Fertility

At Creative Fertility, where the majority of recipients declined donors, recipient agency was restricted by the organisation of the matching process. Recipients were offered a single donor at a time, waited between 6-12 months to be matched with a donor and were provided with little information about their donor via e-mail. The large size of the clinic meant that recipients seldom saw the same nurse for their appointments. Underlying recipients' discourses of declining donors were concerns that went beyond the actual characteristics possessed by donors (which were explored at the beginning of this chapter). Rather, recipients' discourses of declining donors were intertwined with their negative perception of clinicians and the matching process.

Recipients recognised that Creative Fertility was a large fertility clinic with a lot of staff. They described having a lack of a consistent relationship with any one individual clinician on the egg donation programme and referred to their contact and communication with clinicians as being "minimal", "impersonal" and 'unsympathetic' and "disappointing". These recipients seldom spoke about trusting

clinicians. Recipients' critical view of clinicians, nurses in particular, is illustrated by the quote below from Helen:

"It seemed like minimal contact. Because the relationship, that's what you have with the nurses, it was minimal, it was a bit confusing, and yeah, I needed more hand holding. I was swapped from nurse to nurse, there was no real relationship there [...] By the end of the process I didn't like them. I didn't feel like they had a genuine understanding of my situation and what I was going through." [Helen, Creative Fertility]

This lack of a "real relationship" appeared to influence recipients' satisfaction with the process of matching and the donors that they were offered. Recipients felt like they had a lack of information about and a lack of control over the donor allocation process, reflecting that, in retrospect, they were unhappy with their experience of matching at the clinic. These recipients questioned the role and decision-making of clinicians within the matching process and described the matching process as being "non-transparent", "impersonal" and undertaken "behind closed doors". They questioned the fairness of the waiting list and felt that clinicians were unwilling to be "open" and "transparent" about their own role in matching, as illustrated by the quote below from Helen (mentioned above):

"I didn't feel it was accountable at all, because it was so un-transparent, it seems like oh there's a whole other process behind this that I'm not aware of [...] You have no way of knowing. They weren't prepared to be any more open about the process it seemed."

When stating their preferences for donor characteristics recipients reported feeling "rushed" and "confused" about the available pre-existing characteristics and categories. Several recipients described this process as akin to scribbling down' their preferences on 'the back of an envelope' and questioned to what extent clinicians took them into account when matching, as shown by the quote below from Caroline:

“I think the matching process at Creative Fertility is inadequate. The characteristics that I could specify were too broad and too limited. It’s like they scribble them down on the back of an envelope and then go away and try and do something with it.” [Caroline, Creative Fertility]

Most recipients waited at least 6 months to be matched with a donor, which appeared to compound their feelings of a lack of control. During this time, recipients received little contact from the clinic. Many recipients described the period of waiting to be matched with a donor as being “anxious”, “difficult” and “uncertain”. Some recipients questioned whether clinicians allowed other recipients to ‘queue jump’ or whether they might be “forgotten” because of the large size of the clinic, as illustrated by Caroline:

“The waiting I found it psychologically difficult as well, kind of like being in limbo [...] I think it’s a control thing. Because it’s like a big queue, where you don’t know where you are. And my paranoia is that I’m being either forgotten, or that, is it that somebody does a bit of queue jumping.” [Caroline, Creative Fertility]

Although it may seem counter-intuitive that recipients declined donors after waiting for such a long time (given the extra delay to their treatment), for the recipients in this study the long time spent waiting for a donor also made them more critical of the matching process. The notion that ‘we have waited so long we might as well wait a bit longer’ was common in recipients’ accounts of declining donors. The most common reason for recipients’ refusal of donors at Creative Fertility was donors’ weight (as explored earlier in this chapter). Recipients reported being “scared” about the weight difference between themselves and the donors they declined on account of their donor being bigger.

Recipients questioned whether the donors they had declined were offered to them “by mistake” or because they had been declined by other recipients. The quote below from Brenda, who declined a donor who was 28kg heavier than her, illustrates recipients’ lack of trust in clinicians and their disappointment with the donors that they were matched with:

“She was sort of, I remember 88kg and 5’4, whereas I am 5’10 and 60kg. so I was quite surprised. I actually phoned up and said is that a mistake? I think it was Jemma [nurse] who I spoke to who said she is the upper end. I was quite surprised about that. So then I thought right, maybe we had got that offer because everyone else had turned her down.” [Brenda, Creative Fertility]

Several recipients felt that the donors they declined did not meet their stated preferences of exclusion. For example, two recipients reported being “shocked” when they were allocated a donor with red hair because they thought they had excluded donors with red hair when stating their preferences with clinicians. What was particularly disconcerting to these recipients was that clinicians had not taken into account their original request, which made them question the matching process and further reduced their trust in clinicians.

For example, Helen had told clinicians that she wanted to “rule out” donors with red hair. Having declined one donor because she had endometriosis, Helen was then offered another donor with red hair. This led to a breakdown in trust for Helen, who felt she had gotten “lost in the system” and subsequently questioned the matching process and the role of clinicians within it. The lack of a personalised relationship to mediate Helen’s disappointment is illustrated by the quote below in which she recounts this event:

“And then we waited, I think 2-3 months, and then we were offered another donor. But actually she didn’t fit the criteria that we had specified [...] it was a real mess. We had specified certain physical characteristics that we wouldn’t accept, like red hair. And the donor they had offered me was a lady

with red hair! That was a real shock [...] That's a fairly big omission on the part of the clinic. So it began to crack my confidence in them. I think, I'm trying to remember, did the nurses introduce themselves before they had anything to tell me?" [Helen, Creative Fertility]

Another barrier to recipients' acceptance of donors was the amount of information that recipients received about donors from nurses. Most recipients at Creative Fertility described the information they were given about donors as "de-personalised" and "limited". Some recipients spoke about trying to "extract" additional information about their donor from nurses, but reported that their requests were often refused, as illustrated by the quote below from Ayesah:

"We assumed because it is anonymous that the information that they can give you is really limited [...] I tried to find out more about her height, her family, or anything, but they really wouldn't [...] I mean we got some information extracted from them." [Ayesah, Creative Fertility]

Recipients felt that the clinic's method of e-mailing donors' characteristics when offering donors was impersonal and that they were rushed into making a decision, as shown in the quote below from Caroline:

"They just e-mailed me the characteristics of a donor and asked me to let them know in 2-3 days." [Caroline, Creative Fertility]

Recipients questioned nurses' descriptions of donors being a "good match", including their motivation for such a description and the criteria on which this was based. For example, recipients questioned whether nurses' descriptions were a "sales technique" to encourage them to accept donors and whether clinicians told them the truth about the donors they were offered. Here recipients highlighted the commercial context of the clinic over the medical professionalism. When donors did not meet recipients'

expectations of a ‘good match’, recipients questioned clinicians’ authority and wanted more control and information, as illustrated by the quote below:

“I felt this big thing of ‘it’s a good match for you’ and then without elaboration, and I was like ‘what? What does that even mean? That’s my decision!’ ...So I got very frustrated with them.” [Helen, Creative Fertility]

Because recipients were given such little information about their donors they felt that they had little choice other than to “read into” the little information they did receive. For example, two recipients declined donors, in part, on the basis of their lack of education and occupation, e.g. being a hairdresser or carer. Both recipients recognised that they were making assumptions about donors’ level of intelligence based on their educational level (up to NVQ) and occupation, but felt they had little other information from clinicians to mediate these assumptions. This view is illustrated by the quote below:

“I needed a picture of the donor as a person, not just that she’s a hairdresser. There’s so little information about them that you read more into it. But if I knew more about the donor as a person, or her circumstances, for example, if she didn’t do her PhD because she was caring for her mum, then I could understand it a bit more. But you read too much into it if there is too little,” [Caroline, Creative Fertility]

In the context of lacking information and control over the matching process, recipients at Creative Fertility often spoke about declining donors as a source of agency. Here, recipients highlighted the importance of following their “gut feeling” and raising concerns in an otherwise highly technological and medicalised context. Thus some recipients saw declining of donors as a way of retaining a degree of control over the matching process, as illustrated by the quote below from Camille:

“I did say that I refused someone. Somehow it’s a bit stupid, but it was a conjunction of things, a combination of things, and overall, I didn’t feel it. On the one hand, it’s a very medical process. On the other hand it’s not at all. The

control is not total for everybody at every step. But for me, the fact that I didn't feel it, I was inclined to follow my feelings [...] I wasn't sure she would be a good donor somehow. I had doubts. It's not that everything is based on very rational arguments." [Camille, Creative Fertility]

The majority of recipients felt that the donors they were offered were “unsuitable” and so challenged clinicians decision-making by declining these donors. Recipients’ lack of information and lack of a personalised relationship with clinicians meant that there was little to mediate disruptions to recipients’ expectations and ambiguity about the donors they declined. Thus, recipients adopted an ‘active patient/consumer’ role when declining donors (Lupton, 1997).

Because recipients provided retrospective accounts of their experience of the matching process, it is not possible to know at what point recipients began to lack trust in clinicians (e.g. before or after being matched with donors). However, it was clear from recipients’ discourses that a lack of trust in clinicians and their experience of the matching process shaped their practices of declining donors.

Recipients’ perceptions of clinicians rarely featured in their discourses of accepting donors at Creative Fertility. Rather, recipients emphasised the contextual constraints of time and a shortage of donors as shaping their decision to accept donors, as explored earlier. This is in sharp contrast to discourses of recipients at The Fertility Centre, where recipients’ perceptions of clinicians were central to their discourses of accepting donors but rarely featured in their accounts of declining donors, as will be explored below.

The Fertility Centre

Recipients were afforded more agency in the matching process at The Fertility Centre, where the majority of recipients accepted (one of) the first donor(s) that they were offered. Recipients could be offered multiple donors to choose between, were often matched in less than a month of joining the clinic and were offered donors during a face to face consultation in which a nurse provided in-depth and detailed information about donors to recipients. Furthermore, recipients typically saw Noreen and Doctor Rana, who were the only full-time clinicians, when they attended the clinic.

The discourses of recipients at The Fertility Centre were markedly different from recipients at Creative Fertility. At The Fertility Centre, recipients were generally satisfied with all stages of the matching process, which appeared to be based on their positive relationship and interactions with clinicians. Recipients seldom questioned clinicians' authority or the matching process. Instead, the theme of 'trust' was prevalent in recipients' discourses, particularly when discussing why they accepted their donor and accepted difference with their donor. Unlike at Creative Fertility the role of clinicians rarely featured in recipients' accounts of declining donors at The Fertility Centre.

Recipients frequently declared their love, praise and appreciation for Doctor Rana and Noreen, whom they described as "sympathetic", "friendly", "honest" and "warm" people. Recipients emphasised the "close relationship" and "great connection" that they shared with these clinicians and the subsequent "trust" that they had in them to make decision on their behalf. Several recipients had been having treatment at the clinic for several years and had developed a long-standing relationship with Doctor Rana and Noreen. Recipients recognised that The Fertility Centre was a relatively small clinic and felt this was part of the reason that staff could give them such

personalised attention and have inter-personal knowledge of them, as illustrated by the quote below from Dipti:

“Oh my gosh we love them, they know me inside out [...] it’s just nice, and this is what they do so well as a clinic. And I hope that don’t change and perhaps they might do because as it gets busier, and more patients and more demand, but they are just a friendly team.” [Dipti, The Fertility Centre]

Relative to recipients at Creative Fertility, the recipients at The Fertility Centre described having a positive experience of the matching process, including stating their preferences, of the donors they were offered and the amount of information they received about donors. Most recipients said they were matched “quickly” and reported few anxieties about waiting for a match. They were grateful for clinicians’ guidance on accepting donors and felt that their questions about donors were answered satisfactorily by clinicians during their face to face consultations with a nurse.

Recipients described having both ‘inter-personal trust’ and ‘social trust’ (Mechanic, 1996) in clinicians to match them with a donor and this feeling of trust was central to recipients discourses of accepting a donor. In this regard, recipients’ discourses and practices reflected that of ‘passive patients’, as they trusted clinicians moral integrity and medical competency and did not challenge their authority (Lupton, 1997). Recipients described clinicians as being “medical experts” and as having the “professional experience” and competence to undertake matching on their behalf:

“You trust the medical professional to make the correct decision there based on their experience. That’s what you’re asking them for.” [Aileen, The Fertility Centre]

“She’s the expert, she’s been doing it, matching people for years and years, so I have to trust in her that she’s making the right decision for me.” [Tina, The Fertility Centre]

Recipients framed clinicians as having their best interests at heart and recited clinicians' rhetoric of giving them the donor they "deserve". They described trusting clinicians to provide them with the "best" or "right" donor for them and valued clinicians role in matching. Recipients felt that clinicians had personalised knowledge of their characteristics and preferences for donor characteristics and trusted their descriptions of donors being a 'good match', as illustrated by the quote below from Dipti:

"The trust that I had in Doctor Rana and in Noreen, who was in charge of finding the egg donors, she was the one that said 'this is the person for you', because I know you, you've been here for a year, and this is who I think that you should go for. Having trust in the professionals, in Doctor Rana to say, I've met this girl, I know this girl [the donor]. And I believe her when she says 'we will find the best donor for you, we will not just have any donor for you, I will make sure that the donor you have is the donor that you deserve'. And I believe that." [Dipti, The Fertility Centre]

Recipients (particularly CMV negative recipients) were aware of the clinic's policy of matching donors and recipients according to CMV status and drew on this medical matching criterion as a reason for trusting clinician's to make a 'medically safe' match. These recipients were aware of a shortage of CMV negative donors in the clinic and saw this policy as restricting their choice of donor and constraining their preferences.

Despite being aware that other fertility clinics did not match by CMV status, recipients often internalised this 'medical' criterion and viewed their restricted access to CMV positive donors as being due to a 'medical problem' within themselves. The quote below from Tina, a CMV negative recipient who wanted a compensated donor with blue/green eyes, illustrates the constrained choice experienced by these recipients and their foregrounding of the clinic's medical criteria over their own preferences for donor characteristics:

“The biggest problem with me is that I’m CMV negative. So if they had 10 donors that fitted the characteristics, they would’ve all been CMV positive. So trying to find the characteristics and a CMV negative donor is obviously a bit like a needle in a haystack. So they [clinicians] suggested that rather than waiting for months and months for a CMV negative donor with my characteristics to come along, that we go for the egg sharer with hazel eyes.”
[Tina, The Fertility Centre]

In trusting clinicians as best placed to undertake matching on medical grounds, many recipients also spoke about their own role as being to “manage” their “emotions” and their “anxieties” in the matching process and to allow ‘the professionals’ to ‘do their job’. This could help explain why fewer recipients declined donors than at Creative Fertility, i.e. by accepting clinicians’ choice of donor and not challenging this, as illustrated by the quote below from Calvin, the partner of a recipient:

“But there’s other considerations, like if that person is medically a safe match for you, there’s so many different factors. Things like the CMV, the blood type, any historical factors in that person’s family that may contribute to success or failure, so they’re the things that have given me confidence in the process [...] What’s relevant is the health factors, and their CMV and stuff to make it successful, and that that child has a decent life without being born with hereditary stuff that we weren’t aware of. So it’s about us managing our anxiety and trusting the professionals to do their job.” [Calvin, The Fertility Centre]

Although recipients appeared to occupy a passive role when accepting donors, their practices might also be interpreted as form of agency through objectification (Thompson, 2005) in which recipients foregrounded their trust in clinicians in order to meet their primary aims of having a medically safe match, timely treatment and a healthy child (over and above their preferences and resemblance). However, observations of donor offering sessions at The Fertility Centre also revealed the ways in which clinicians shaped recipients’ decision-making and encouraged them to accept donors during ‘Donor Offering’ consultations. Here, it was common for clinicians to provide recipients with detailed and subjective impressions about donors, including

about their personality, facial features, accent, hobbies, future aspirations, family relationships and immigration history.

However, although clinicians provided recipients with more information, this information was carefully managed to encourage recipients to accept a donor under offer. Often, Noreen, the head nurse, sought to encourage recipients to accept (one of) the donor(s) under offer by highlighting donors' positive attributes, by constructing resemblance between donors and recipients and quantifying resemblance between donors and recipients. For example, it was typical for Noreen, and other clinicians, to describe donors to recipients in positive terms, including "attractive", "beautiful", "intelligent", "cheerful", "family-orientated", "outgoing", and "selfless", sometimes without prompt from recipients. The excerpt below from observational field notes of a 'Donor Offering' consultation illustrates how clinicians foregrounded the desirable attributes of donors:

This donor is beautiful, I remember that. Oh, and she had big eyes, like you [the recipient]. And she is a flight attendant, so she's certainly be pretty enough for BA [British Airways] standards. [Field notes, week 20, The Fertility Centre]

Noreen also constructed more personalised forms of resemblance between donors and recipients when offering donors, which involved telling recipients that they shared a similar shade of skin tone, hair texture/style, personality, facial features, religion or accent as the donor they were matched with. Such resemblances were constructed by Noreen in spite of a range of differences between the recorded characteristics of donors and recipients. The excerpts below from observations of 'Donor Offering' consultations illustrate the ways in which Noreen 'sold' resemblance to recipients. In all of the cases below the donors that were being offered to recipients did not match all of the recipients' original preferences:

“She has similar features to you, and has a soft voice, just like you”

“She has the same hair colour as you naturally, but she dyes it.”

“She has curly hair, just like you.”

“She looks just like you, your face shape and features.”

“She is British, and has a proper cockney accent, just like you.”

(Field notes, Observations of Donor Offering Sessions: Day 1; Day 6; Day 1; Day 9; Day 14)

It was also common for Noreen to quantify resemblance between donors and recipients by informing recipients that their donor was a “95%” or “99%” “match” with recipients own characteristics or their preferences. Such high percentages would be given to the majority of recipients in spite of multiple differences between donors and recipients. For example, in one case, Noreen described a match as being “95%” despite the donor weighing 18kg more than the recipient and not meeting their preference for eye colour and education. In the context of donor anonymity, where recipients relied on clinicians for access to information about their donors, the contradictory nature of such subjective and statistical descriptions were difficult for recipients to question or verify.

When offering multiple donors to recipients, clinicians also labelled donors in chronological order of physical match, with the number 1 being the “closest”. Despite otherwise telling recipients to go with their “gut feeling” when deciding which donor to accept, clinicians often highlighted the ‘pros and cons’ of each donor and often guided recipients towards choosing one. During observations of consultations where recipients were offered multiple donors to choose between there appeared to be an inherent assumption in the room that recipients were expected to choose one of the

donors they were offered. Because recipients were offered donors during a face to face consultation, they may also have felt pressured to accept a donor in the presence of clinicians (unlike at Creative Fertility, where this exchange was done remotely via e-mail).

When rationalising why they accepted a donor with different characteristics to their own recipients commonly reiterated clinicians' description of their donor being a high percentage match, as illustrated by the quote below:

“And the one that she [Noreen] saw is like a 90-95% match of what we original told her so why would we want to look further.” [Aileen, The Fertility Centre]

Recipients also drew on clinicians' rhetoric of donors being a 'close match' and possessing desirable characteristics to alleviate their concerns about donors having different characteristics to their own. For example, Amandeep, an Indian recipient, raised her apprehension about accepting a Sri Lankan donor with Noreen. As illustrated by the quote below, Amandeep foregrounded Noreen's description of her donor being an 'exception to the rule' (of people from Sri Lanka having darker skin tone) and resembling herself:

“Because Sri Lankans are generally of a darker skin tone, so we did ask that question, but we were told that she is definitely not of a darker skin tone. We don't mean like, your skin tone [interviewer] and ours [recipient and her partner], but really really dark. But Noreen [nurse] said no, because you do get certain areas where they are lighter, that was the only thing. We just don't want them to look very different [...] She said that it's [the donor] like a medium complexion, with a long face, similar to mine, similar body weight and stuff like that.” [Amandeep, The Fertility Centre]

8.5 Conclusion

This chapter has explored how recipients negotiated accepting and declining donors that they were matched with and how they navigated the differences they were and were not willing to accept. Recipients strategically drew on discourses of contextual constraints, genetic inheritances, kinship and resemblance, desirability and stigma, trust and control, and inclusion and exclusion, to rationalise their decision making when declining and accepting donors and negotiating difference.

Although recipients were willing to accept donors with different characteristics to their own this wasn't the case for all types of differences. Recipients declined donors with marginalised and stigmatised characteristics, a practice which was coherent with their preferences of exclusion. Thus donors with red hair, a high BMI, dark skin tone and who identified as Muslim or lesbian were systematically excluded by recipients. When declining donors, recipients foregrounded the criteria they wanted to exclude in their donor, and child, over the importance of time and over any desirable characteristics that the donor possessed.

The characteristics outlined above to varying degrees are all associated with “societal deviance”, i.e. they are widely perceived as being deviant and hence stigmatised (Falk, 2001). Numerous studies have reported on the stigmatisation, marginalisation, discrimination and prejudice against red hair (Cooper, 1971; Feinman and Gill, 1978; Clayson and Maughn, 1986; Heckert and Best, 1997), ‘obesity’ (Cahnman, 1968; Puhl and Brownwell, 2002), Islam (Nahman, 2006; Razack, 2008; Inhorn et al., 2009), homosexuality (Israel, 2002; Nordqvist, 2010) and dark skin tone (Nahman, 2006; Hunter, 2007; Thompson, 2009; Schurr, 2016) in ARTs and society more generally. Although discrimination against educational background has not generally been a prime focus of studies, associations between low educational levels and the

marginalised characteristics of low class and lower intelligence have been reported (Hernstein and Murray, 1994).

This study has illustrated that donors with marginalised characteristics were less likely to be accepted by recipients. Unlike other differences, which recipients saw as a ‘discreditable kinship risk’ that could be mediated, recipients saw having a child with stigmatised characteristics as a ‘discredited kinship risk’, which they felt unable to mediate. Although recipients ability to decline donors reflected an important source of recipient agency, in exercising this particular agency recipients reified and reproduced inequalities in wider society in their reproductive choices and stratified reproduction by excluding donors with stigmatised (and devalued) characteristics.

In doing so, donors’ access to genetic reproduction was discouraged as was the reproduction of stigmatised characteristics in recipients’ own family. For egg sharing donors in particular, such exclusions also stratified access to their own reproduction as their subsidised access to fertility treatment was dependent upon being accepted by a recipient. Although recipients were not willing to compromise on their exclusionary preferences for donor characteristics they were willing to compromise on their preferences of inclusion.

The majority of recipients spoke about accepting a donor with different characteristics to their own. When rationalising why they accepted donors with different characteristics recipients foregrounded contextual constraints of a shortage of donors and a perceived shortage of time. Contrary to Lindheim and Sauer’s (1998) findings then, the passage of time did impact recipients’ practices and led them towards accepting a donor. Thus, for the recipients in this study the process of accepting a donor was about rationalising and accepting difference rather than merely constructing resemblance.

Recipients' discourses of rationalisation revealed nuanced forms of recipient agency in which they strategically rationalised differences with their donor in order to rationalise accepting them. Recipients foregrounded the role of 'fate', drew on the presence and absence of resemblance within families and alternative genetic discourses of inheritance and constructed social-cultural connections between themselves and the donors they accepted based. These social connections enabled recipients to identify with their donor in an otherwise anonymised context. Recipients saw the differences they accepted in their donor as 'discreditable stigma' (Goffman, 1963), or 'discreditable kinship risk', in that they could be mediated and rationalised.

The context of the clinic was shown to be a key factor in influencing recipients' practices of accepting and declining donors at each clinic. Recipients' trust in clinicians and the organisation of the matching process were central features of this context. At Creative Fertility recipient choice and access to information was restricted, recipients had a poor relationship with clinicians and lacked trust in them and they questioned all aspects of the matching process. In this context, recipients saw declining donors as a source of agency. In the absence of trust and information, recipients found it difficult to mediate difference with their donor and blamed clinicians for providing them with an unsuitable match. For these recipients, a central part of the process of accepting a donor appeared to be declining donors beforehand.

At The Fertility Centre recipient choice and access to information was encouraged, recipients had a good relationship with clinicians and trusted them, they were satisfied with the matching process and saw it as their own role to manage their behaviour by accepting donors. Recipients foregrounded clinicians' medical expertise and clinicians' descriptions of donors when mediating difference with the donor they accepted and so did not decline donors as much.

Chapter 9: Conclusions

9.1 Introduction

This study was prompted by two external impetuses: the (changed) policy environment in the UK on ‘ethnic matching’ in gamete donation and a gap in the existing literature on fertility treatments.

The end of HFEA policy on matching in gamete donation in 2007 marked the end of formal and (arms-length) state-mandated ‘racial matching’ of donors and recipients. Whilst the existence of this policy sparked my initial interest in the topic of matching, I later began to question how matching in egg donation is organised in the UK in the absence of policy guidance. How did clinicians match donors to recipients and how did recipients negotiate the selection of donors in the clinical context? How did clinicians conceptualise ‘ethnic matching’ and what factors shaped their practices of matching? What was the role of recipients in matching and how did they experience this?

This study was also prompted by the limitations of the current academic literature on the subject of matching. Despite its importance in fertility treatment with donor gametes, the intricacies and complexities of the matching process have typically been taken for granted in the UK. Previous studies have only alluded to matching as part of a wider focus on gamete donation or have situated matching as a consumer practice within neo-liberal contexts of egg donation. Unlike previous studies, this study contributes an in-depth study on matching in the UK by putting matching at the focus of analysis. In this concluding chapter I will begin by recapping the research questions, and their answers, and summarise the central empirical findings of this thesis. This will be followed by a discussion of the implications of these findings and

the main theoretical contributions of this study. I will end with consideration of the limitations of this study and some recommendations for further research.

Research Questions:

The overarching research objective of this study was to explore the organisation of donor-recipient matching in egg donation in the context of 2 fertility clinics in the UK. The main conclusions of this thesis are that matching is a process and that this process contributes to a medicalisation, racialisation and stratification of reproduction. These conclusions are situated within the wider regulatory and immediate clinical contexts of egg donation and matching.

The empirical chapters presented in this thesis were based on 4 research questions, informed by the literature:

- How do clinicians classify donors and recipients into categories?
- How do clinicians allocate donors to recipients?
- How do recipients express and negotiate their preferences in the context of the clinic?
- How do recipients negotiate accepting/declining donors they are matched with?

In this concluding chapter I am going to first summarise my central empirical findings according to the sub-research questions above. This will be followed by a discussion of the main theoretical contributions and implications of these findings. I will end by outlining the limitations of this study and recommendations for further research.

9.2 Key Findings

9.2.1 How Do Clinicians Classify Donors and Recipients into Categories?

In Chapter 5, the ways in which clinicians classified donors and recipients into formal, informal and implicit categories were explored to show how the process of classification reproduced and reinforced wider system of stratification, including medical paternalism, normative reproduction and racialised hierarchies. This involved examining how clinicians classified donors' and recipients' 'race'/ 'ethnicity', physical and social characteristics, how clinicians shaped recipients' preferences for donor characteristics and how clinicians classified recipients as compliant ('good') and non-compliant ('demanding') based on their matching practices. This chapter showed how clinicians decided on which types of differences were made meaningful and recorded and which were not.

Clinicians' reduction of donors and recipients into different physical and social characteristics revealed the arbitrary and socially constructed nature of seemingly objective and discreet categories. Although clinicians decided on which types of differences were made meaningful, their practices were shaped by a wider regulatory framework which determined the characteristics and categories that they had to collect about donors. The outcome of such classifications were often a complex interplay between: the categories available for recording characteristics, how clinicians posed questions to donors and recipients and the information they disclosed, donors and recipients perceptions of their own characteristics and the categorisation recorded by clinicians. Clinicians classified donors and recipients through a process of 'racialisation' (Miles, 1989) and categorised individuals as 'white' or 'BME' depending on their own perceptions of skin tone. Thus clinicians reified and reproduced 'race' as a physical and genetically inheritable characteristic.

When classifying recipients' preferences for donor characteristics clinicians shaped recipient agency according to their own expectations of the recipient role. Crucially, while clinicians considered it acceptable, even necessary, for recipients to accept difference because of a shortage of egg donors they did *not* see it as acceptable for recipients to actively choose difference, especially in relation to 'racial' difference. Clinicians saw it as their role to ensure that "abnormal" recipient preferences were disallowed and framed such preferences as in direct conflict with the welfare of the child (echoing previous HFEA policy). Clinicians' perception of 'racial difference' for white recipient as 'exotifying' and BME recipients as 'improving' the characteristics of their child also reflected the complex power dynamics of racialised hierarchies.

Clinicians' expectations of recipient agency also shaped their stratification of recipients as 'good' or 'demanding'. Clinicians saw recipients who exerted 'too much agency' in the matching process as 'demanding' and as a threat to their own authority. They medicalised the behaviour of 'demanding recipients' as being due to unresolved anxiety rather than autonomous decision-making or their choice of donor. As such, they reasoned that recipients who were not compliant with their expectation of recipients were inherently uncomfortable with using donor eggs (the medical solution) and in 'denial' about their own infertility (the medical diagnosis). Thus, 'demanding' recipients were seen as not trusting clinicians' decision-making in matching and more generally. Clinicians used counselling as a tool to manage the behaviour of these recipients and to encourage them to become more compliant, i.e. to have 'suitable' preferences and to accept donors.

9.2.2 How do Clinicians Allocate Donors to Recipients?

Having explored how clinicians categorised the characteristics of donors and recipients in the previous chapter, in Chapter 6 the ways in which clinicians

subsequently allocated donors to recipients based on these categories were explored. This chapter looked at clinicians' negotiation of clinical matching criteria, which comprised 'secondary matching criteria', i.e. the waiting list, recipients' preferences and general physical resemblance, and 'primary matching criteria', i.e. height/weight or CMV status and 'race'/skin tone. Clinicians' allocation of donors based on their perception of recipients was also explored.

The findings presented in this chapter illustrated how clinicians' discourses and practices of matching revealed a medicalisation and racialisation of reproduction and the stratification of reproduction and medicalisation according to nuanced racialised cleavages. It was shown, for example, how clinicians' prioritisation of matching criteria varied when clinicians were matching white recipients or BME recipients, prioritising different criteria in each case.

Clinicians saw a primary aim of their role in matching as protecting the medical welfare of children born through egg donation and to ensure the medical safety of recipients of donor eggs. However, the prioritisation of different 'medical' matching criteria at each clinic illuminated the socially constructed nature of these imposed medical categories, as did clinicians' willingness to compromise on this criteria when matching BME donors and recipients.. The differential treatment of BME recipients in this respect revealed clinicians' prioritisation of 'race' and skin tone as the most important matching criteria.

Clinicians saw 'racially matching' donors and recipients as the most important aim of matching and as protecting the social welfare of 'children' born through egg donation. Fundamentally, clinicians singled out 'race' as a primary indicator of kinship and 'racial difference' as a primary 'kinship risk', i.e. a risk to the display of kinship resemblance. Clinicians' discourses and practices of 'transracial matching' were

particularly revealing of clinicians' conceptualisations and practices of 'racial matching' revealed the nuanced ways in which donor allocation stratified, medicalised and racialised reproduction and how 'whiteness' was reproduced in the clinical context.

Clinicians took intricate steps to navigate 'transracial matching' with the aim of limiting 'racial difference' between donors and recipients and between recipients and their child. In doing so, clinicians sought to curtail BME recipients' reproduction of racialised white features whilst maintaining the reproduction of racialised white features of white British recipients. For example, BME recipients' access to white donors was dependent on clinicians' perceptions of their skin tone, the skin tone of their partner and skin tone of white donors. On the other hand, when matching 'marked white' donors with white British recipients then clinicians strategically 'unmarked' the whiteness of these donors.

Whilst clinicians saw it as acceptable for a BME couple to have a mixed ethnicity child they did not see it as equally acceptable for a white couple to have a mixed ethnicity child. These discourses and practices of 'transracial matching' reveal how an analysis of matching in the present contexts adds novel layers to the stratification of reproduction and (bio)medicalisation. It was illustrated how the reproduction of 'racially congruent' families (Wade, 2012) were valued and encouraged whilst the reproduction of 'racially incongruent' families (ibid) were devalued and discouraged. Reflecting the regulatory context in which matching took place, this stratification was not based on money but on moralised concerns about the welfare of the child. In this context, 'race' and 'ethnicity' are depicted as a 'risk' by clinicians, to be managed, and not just as a commodity. Such practices also stratified recipients' access to egg donors on the basis 'race' and skin tone.

Descriptive statistics of ‘racial matching’ at each clinic enabled insight into the patterns and outcomes of clinicians’ matching practices and revealed that clinicians’ practices of matching were coherent their perceptions and that the majority of allocations made by clinicians were ‘racially’ matched. This has significant repercussions for the types of families that were reproduced in the clinics through egg donation. Finally, this chapter illustrated how clinicians’ perceptions of recipients as ‘demanding’ shaped their practices of matching whereby they avoided matching ‘non-compliant’ recipients as a mechanism of managing their own workload and managing the expectations of recipients. The strategy of not matching particular recipients was undertaken with the aim of neutralising recipients’ active and non-compliant agency (declining donors) into a passive and compliant form of agency (accepting donors).

Taken together, these findings demonstrate that the ways in which clinician’s allocation of donors to recipients illustrate a medicalisation, stratification and racialisation of reproduction. Clinicians sought to reproduce a normative model of the family through discourses of ‘risk’, ‘racialisation’ and ‘strategic naturalisation’ by strategically managing the crossing of normative racialised boundaries.

9.2.3 How do recipients express and negotiate their preferences in the context of the clinic?

In Chapter 7, recipients’ preferences of inclusion and exclusion for donor characteristics and their preference for donor information were explored. Recipients felt stigmatised as recipients of donor eggs, both in relation to their own infertility and because they would not share a genetic relationship with their child. Recipients were concerned that a lack of resemblance between themselves and their child would reveal this ‘spoiled identity’ (Goffman, 1963) and lead to ‘relational stigma’. Recipients thus

wanted a donor who matched their own characteristics in the hope of having a child who would ‘pass as if’ it were their genetic offspring. In this regard, recipients’ preference for resemblance can be interpreted as a form of self-surveillance, in which recipients had little choice but to match for resemblance and replicate a normative ideology of the family. The ideologically constrained nature of this preference was further illuminated by the discourses of male same-sex interviewees, who actively chose not to subscribe to heteronormative ideals of reproduction and kinship through matching for resemblance.

When discussing their preferences for donor characteristics recipient foregrounded the importance of genetic inheritance and of resemblance as a primary indicator of kinship. Recipients conceptualised ‘ethnicity’ as a physical and genetically inheritable characteristic, i.e. as ‘race’. Like clinicians, recipients conceptualised ‘race’ as a primary indicator of kinship and ‘racial difference’ as a kinship risk, i.e. to the display of kinship resemblance and leading to ‘resemblance talk’ (Becker et al., 2005). However, recipients differed in their conceptualisations of resemblance and difference and in their willingness to accept donors from a different ‘racial’ origin.

Whilst white recipients were unwilling to consider a donor from a different ‘race’ and saw ‘racial difference’ as a ‘discredited kinship risk’ BME recipients had considered using a donor from a different ‘race’ and, to an extent, saw ‘racial difference’ as a ‘discreditable kinship risk’. White recipients saw ‘race’ as inflexible, bounded and immutable and were concerned about the reproductive legitimacy of their partner. On the whole, BME recipients saw racialised boundaries as flexible and able to be transgressed, although these transgressions also followed a racialised hierarchy of skin tone. Recipients distinguished between types of white donors and South Asian donors, so that white British recipients excluded ‘marked white’ donors whereas South Asian recipients actively sought them out. On the whole, recipients were

willing to accept a donor with lighter skin tone than themselves but not darker skin tone.

Recipients strategically drew on discourses of geneticisation and risk to exclude donors with minority and stigmatised characteristics, which recipients framed as being ‘too different’ from their own, “normal” characteristics. In particular, recipients singled out donors’ with red hair, dark skin tone, a high BMI and who identified as Muslim as falling outside of the ‘norm’ and thus sought to exclude them from their preferences. Recipients’ conceptualisations of ‘resemblance’ and social desirability and stigma therefore were intertwined.

Recipients’ preference for the amount of donor information they would have liked to have received revealed that recipients faced a paradox of conflicting identities which recipients sought to strike a balance between. On the one hand, reflecting a consumer identity, some recipients wanted more information about their donors to use as a donor selection tool and because they saw this as empowering. On the other hand, the vast majority of recipients saw having “too much” donor information as a risk to their parental identity and the distance they wanted to maintain with anonymous donors. However, recipients who intended to disclose to their child saw having more and identifying donor information as their child’s ‘right’. This finding echoes more recent studies on recipients’ preferences for donor information in contexts of donor allocation (Stuart-Smith et al., 2012; Rubin et al., 2015; Zadeh et al., 2016b) and is contrary to studies which have posited recipients’ consumption of donor information as merely a consumer choice (Becker, 2000; Pennings, 2000).

Unlike previous studies, which have argued that recipients erased (Konrad, 2005) or re-materialised (Klotz, 2014) the role of their egg donor the interviewees in this study appeared to conceptualise donors in a liminal role. On the one hand they sought to

maintain distance between themselves and their donor (i.e. avoid their donor becoming 'too real') whilst on the other hand they did not want to completely deny the existence of their donor as a person (and wanted some information about them).

9.2.4 How do recipients negotiate accepting/declining donors they are matched with?

In Chapter 8, recipients' practices of accepting and declining the donors they were matched with were explored, revealing the complex meanings and negotiations that shaped their perceptions and practices. Recipients' discourses and practices of selecting donors revealed that their exclusion of donors with stigmatised/marginalised characteristics was systematic, e.g. 3 or more recipients declined donors with such characteristics. Echoing recipients' preferences of exclusion, recipients most commonly declined donors on the basis of: having red hair, being 'overweight', being 'marked white', identifying as a 'lesbian' and having no higher education degree. Donors with multiple 'undesirable' characteristics were less likely to be accepted by recipients. As discussed in Chapter 7, recipients conceptualised donors with these stigmatised characteristics as a 'kinship risk' and a risk to their child's health and well-being. Thus, for recipients, these characteristics could not be mediated, or accepted, even though they could potentially be rationalised (e.g. the presence of red hair).

When declining donors recipients foregrounded donors' marginalised characteristics, i.e. the criteria they wanted to exclude in their donor, and child, over the importance of time and over any desirable characteristics that the donor possessed. Thus, recipients conceptualised the marginalised characteristics of the donors they declined as their Master Status (Hughes, 1945) which overrode any meaning attached to

donors' other attributes. In exercising their agency to decline donors recipients' reified and reproduced inequalities in wider society and stratified reproduction in new ways. That is, recipients delayed or prevented these donors from genetic reproduction and simultaneously avoided the reproduction of donors' marginalised characteristics in their own family. These exclusionary practices also had particular consequences for egg sharing donors whose subsidised and stratified access to their own reproduction through the clinic was dependent on being accepted by a recipient.

Recipients' discourses of accepting donors revealed that this process was more about the negotiation and rationalisation of accepting difference than the construction of resemblance. When rationalising why they accepted donors with different characteristics to their own recipients foregrounded contextual constraints of a shortage of donors and time and minimised the importance attached to their original preference for resemblance. Recipients' discourses of rationalisation revealed nuanced forms of agency in which recipients strategically naturalised (Thompson, 2005) and rationalised differences with their donor in order to accept them. Recipients drew on fatalistic discourses, the presence *and* absence of resemblance within their wider families and constructed socio-cultural connections between themselves and their donor.

In contrast to when stating their preferences for donor characteristics, where recipients foregrounded the importance of resemblance as a primary indicator of kinship and notions of geneticisation, when accepting donors recipients strategically utilised alternative discourses of genetic inheritance and disentangled the relationship between kinship and resemblance. Recipients thus saw the differences they accepted in their donor as 'discreditable kinship risk' in that they could be mediated, concealed and legitimised through discourses of rationalisation. Therefore, although recipients were

willing to compromise on their preferences of inclusion for donor characteristics they were less willing to compromise on their preferences of exclusion.

The impact of context was also shown to shape recipients' perceptions and practices of selecting donors. Recipients' trust in clinicians and the organisation of the matching process were shown to be key determinants of recipients' selection of donors, illustrated through the different rates at which recipients' declined donors at each clinic. At Creative Fertility, where recipient agency was more constrained and recipients questioned clinicians' authority, the majority of recipients declined the first donor they were matched with, whilst at The Fertility Centre, where recipient choice was more encouraged and recipients trusted clinicians' decision-making, the majority of recipients accepted the first donor they were matched with.

9.3 Contributions to the literature

This study makes theoretical contributions to four main bodies of literature: (bio)medicalisation theory, reproduction and kinship, stratified reproduction and 'race'/ethnicity. Contributions to the latter three areas literatures will be discussed in relation to (bio)medicalisation theory which was chosen as the overarching theoretical framework for this study. In contrast to prevailing discourse in the field of ARTs, which have focused on the commodification of reproduction, I have shown that reproduction is medicalised, stratified and racialised and that commercialisation is limited in the UK context of egg donation, specifically through donor-recipient matching. The contributions made to these fields will be outlined below.

9.3.1 (Bio)Medicalisation Theory

This research responds to Clarke et al.'s (2010) call for more case studies of (bio)medicalisation in international contexts outside of the USA through the exploring

of matching in the UK context of egg donation. A central contention of (bio)medicalisation theory is that there has been a decline in medical jurisdiction over the last 30 years (Clarke et al., 2010). According to Clarke et al., (2010), the increasing commodification of healthcare, the rise of biotechnologies, changes in the production and distribution of information, a focus on health rather than illness, the rise of risk society and self-surveillance and a decline in trust in experts have led to the need to reconsider the applicability of medicalisation thesis (Clarke et al., 2010).

Conrad (2013) too has emphasised that the rise in ‘consumerism’, ‘managed care’ and ‘biotechnology’ have challenged clinicians’ dominance and autonomy but unlike proponents of the (bio)medicalisation thesis he argues that these changes have been the main drivers of the expansion of medicalisation in recent decades rather than challenges to. Whilst scholars agree that the medical profession have become more peripheral in driving medicalisation and that ‘active consumers’ and other market players pose direct threats to professional medical power there is less agreement about the implications of these threats for medicalisation at a conceptual level (Ballard and Elston, 2005; Conrad, 2005; Clarke et al, 2010; Busfield, 2017).

It is useful to note here that frameworks of medicalisation and commercialisation have predominantly originated and been developed in the US context of healthcare. Notions of the ‘medical-industrial complex’, ‘managed care’, ‘corporatization of healthcare’ and neo-liberalism so intertwined with conceptualisations of healthcare and ARTs in the US and (bio)medicalisation theory (Clarke et al., 2010) do not apply so straightforwardly to the UK context, in which healthcare and ARTs have a mixture of public and private funding and are highly regulated by the state (Moran, 1999; Tanzi, 2002; Walshe, 2002; Glennon, 2012). The relationship between the state, the medical profession, patients and the market in the UK therefore has its own peculiarities. In this context, scholars have highlighted how levels of trust in the

medical profession are not as low as in the USA and the importance of not conflating trust in doctors at an individual level and a social level (Mechanic, 1996; Lupton, 1997; Calnan and Sanford, 2004).

Throughout this thesis the term “Biomedicalization” was used in an adapted way: the term ‘bio’ was pre-fixed in brackets (Bell and Figert, 2015) and the UK-English spelling, i.e. the use of “s” rather than “z”, were explicitly chosen to highlight the importance of considering how (bio)medicalisation theory might be applied to the UK context. In using this edited version of (bio)medicalisation I have intended to indicate more than merely the theory’s limitations (Bell and Figert, 2015) and a personal grammatical preference. The use of this amended term also indicates some of the limitations of medicalisation theory and the potential value of (bio)medicalisation theory in moving beyond these limitations (hence employing the term in this thesis).

In this study medicalisation theory was less well suited for grasping the specific reproductive, consumer, genetic, techno-scientific, heterogeneous and uneven natures of ARTs. On the other hand, (bio)medicalisation theory was less well suited for explaining the expanding role of the medical profession, the role of the state and regulation and the specific nature of constrained consumerism, all of which were integral aspects to the findings of this study. The findings of this study challenge a number of assumptions in (bio)medicalisation theory, including that there has been a decline in medical jurisdiction and state intervention (Clarke et al., 2010; Conrad, 2013) and that recipients of ARTs are primarily consumers (Becker, 2000; Mamo, 2005). This study contributes to medicalisation theory by illustrating how the expansion of medical jurisdiction can still be a key driver of medicalisation, how ‘race’ is reified through biomedicine (explored below) and how medicalisation is uneven in its processes and effects.

Consumerism and medicalisation are two central features of (bio)medicalisation theory. However, Clarke et al., (2010) have predominantly emphasised the commercialised nature of (bio)medicalisation and been criticised for diluting medicalisation and taking it for granted (Conrad, 2013). It is recognised that commodification and medicalisation are not antithetical, particularly in the partially privatised arena of ARTs. However, my findings showed a strong persistence of medicalisation and a limit to commercialisation at a number of levels, namely the macro-level of regulation, the meso-level of clinical decision-making and the micro-level of clinician-patient interactions (Conrad, 1980b).

Current theorisations in the literature of matching as a ‘commercialised’ and/or a ‘kinship’ practice did not fully explain the findings of this study. As noted by Breitkopf and Rubin (2015: 46) “more recent scholarship tends to bypass questions of exploitation versus agency and instead examines the broader social and contextual issues at stake in the buying and selling of reproductive matter”. Instead, medicalisation, in spite of its limitations, provided a useful framework for understanding the power relations shaping the interactions between clinicians and recipients. Thus, whilst the wider context within which matching took place was privatised and commercialised the dynamics and organisation of matching within this arena were less framed by consumerist concerns than medicalised ones. Normalisation (medicalisation) not optimisation (biomedicalisation) was seen as the ultimate goal of matching, albeit through optimised techno-scientific means. Following Conrad (2013), consumerism appeared to be more of a driver of medicalisation than a threat to its expansion in this context (Becker and Nachtigall, 1992).

As shown in Chapter 4, in the UK the state is a major stakeholder in fertility treatment and there is a much smaller market for ARTs than in the USA, which is both privately

and publicly funded in the UK. Whilst the funding and provision of healthcare and fertility biomedicine are becoming increasingly privatised, the nature of this privatisation, within a highly regulated context, demands critical and reflexive application of (bio)medicalisation theory to the UK context. The nature of ART regulation sanctions clinicians' dominance and constrains commercialisation by: limiting donor payments, mandating the identifiability of donors and protecting welfare of the child interests. According to Daniels et al., (2016) the mandated nature of welfare of the child considerations inherently intertwines the state, medical professionals and parents, leaving little room for the market in this conceptualisation. The altruistic context of donation more generally in the UK also shapes the relationship between commercialisation and medicalisation (Titmuss, 1997; Glennon, 2012). The expansion in medical jurisdiction and limit to commercialisation were also apparent at meso- and micro- levels of clinicians' and recipients' perceptions, interactions and practices of matching.

The perceptions and practices of recipients in this study did not reflect that of the autonomous, rational and objective 'healthcare consumer', which Henderson and Petersen (2002: 4) argue is an artefact of culture, policy, expertise and marketing in the UK context of healthcare. Although recipients' exclusion of donors with undesirable characteristics did commodify donors' characteristics, their discourses of declining donors revealed that their practices were shaped by wider concerns about the welfare of their child, kinship resemblance and trust in clinicians. Discourses of constraints, compromise and trust in clinicians were central to recipients' accounts of selecting donors. Contrary to the view of recipients as merely as consumers of donor information (Becker, 2000; Pennings, 2000; Kroløkke, 2009, 2014) this study found that recipients saw having more donor information as a burden and as a risk to their reproductive agency (Stuart-Smith et al., 2012; Braverman and Frith, 2014; Rubin et

al., 2015). As such, recipients saw the clinical context of anonymous egg donation as protective (Allan, 2007).

In this study, clinicians controlled all aspects of the matching process, including the classification of donor/recipient characteristics, the preferences that recipients could specify, the allocation of donors to recipients and the amount and type of donor information recipients could access. Both clinics imposed their own medicalised matching criteria, rationalised as being in place to manage medical risks to the welfare of the child and the safety of recipients. Clinicians strategically re-conceptualised ‘demanding’ recipients (i.e. consumers), who challenged their medical authority, as ‘very anxious recipients’ (i.e. patients) who had not come to terms with using egg donation, or their own infertility, and as a threat to the welfare of the child. They thus concluded that these ‘non-compliant’ recipients required intervention in the form of counselling before allowing them to proceed with treatment with the intention that recipients would become more compliant.

In their study of how fertility clinic staff applied Section 13(5) of the Human, Fertilisation and Embryology Act (2008) Lee et al. (2014), argue that medicalisation theory provides a “blunt tool” for understanding the complex realities of service provision in ARTs. One of the reasons they put forward for this argument is that the responsibility for taking into account the welfare of the child was also taken on by non-medical staff, particularly counsellors. Whilst I agree with Lee et al., (2014) that medicalisation theory has its limitations, in this study, I argue that the role of counsellors was co-opted and encompassed within medicalisation so that they were used as a mechanism within medicalisation and contributed to rather than retracted the expansion of medical jurisdiction.

Therefore my adapted use of (bio)medicalisation is intended to reflect the particular findings of this study within the UK context of egg donation in which there was an expansion of medicalisation and a limit to the commodification of reproduction. Below, the contributions of this conceptualisation of (bio)medicalisation as applied to wider areas of sociological literature will be explored, including the implications for kinship, stratifications of reproduction and (bio)medicine and ‘race’ and ethnicity.

9.3.2 (Bio)Medicalisation of Reproduction and Kinship

Since the 1990s, the emergence of ARTs has revitalised sociological interest in kinship studies. According to Schneider (1992: 308) kinship has stayed the same for such a long time “that these cultural definitions have not changed one iota as a result of the new reproductive technologies, nor will these technologies alone cause them to change in the immediate future.” Others, however, have emphasised the numerous ways in which ARTs have opened up new ways of thinking about the interrelated concepts of family, reproduction and kinship and have used ARTs as an ethnographic window through which to explore kinship discourses and practices (Stacy, 1992; Strathern, 1992a, 1992b, 1992c; Ragoné, 1994; Edwards et al., 1997; Franklin, 1997; Franklin and Ragoné, 1998; Kahn, 2000; Franklin and McKinnon, 2001; Carsten, 2004; Thompson, 2005; Featherstone et al., 2006; Wade, 2007; Bonaccorso, 2009).

According to Finkler (2000) the deterministic nature of new genetic technologies has led to a ‘medicalisation of the family’ where the role of choice in constructing relatedness is subverted and determined by genetic relations. This is contrary to theorising of kinship and the family as ‘choice’ (Weston, 1991). However, this thesis has been criticised by Featherstone et al. (2006) who have argued that Finkler’s (2000) ‘medicalisation of kinship’ appears to be more about the ‘geneticisation of

medicine'. Other scholars have also shown how the use of Prenatal Genetic Diagnosis (PGD) and the 'new genetics' has led to a "geneticization of reproductive choice" (Franklin, 2013: 299) where the decision to procreate is determined by genetic considerations rather than socio-cultural ones.

In relation to ARTs, Mamo (2005) has argued that the selection of sperm donors by lesbian couples constitutes a "biomedicalization of kinship" in which she stresses commercialised, geneticised and tech-scientific nature of reproduction and the ability to choose donors according ideals' of health, desirability and power. Noticeably absent from this conceptualisation of the "biomedicalisation of kinship" as applied to this study are medicalisation, the role of the state and the constraints associated with these.

In this study, it might be argued that the organisation of matching in egg donation constitutes a '(bio)medicalisation of kinship' which takes place through the complex and dynamic ontological choreography of making families. Rather than reflecting an attempt to 'optimise' familial characteristics (Clarke et al., 2010; Mamo, 2010) clinicians and recipients perceptions and practices of matching revealed an attempt to reproduce normative families (Spallone, 1989; Steinberg, 1997; Atkinson et al., 2001; Thompson, 2005). Central to such a conceptualisation are two key concepts which were utilised in this study to understand and explain clinicians' and recipients' discourses and practices of matching: 'kinship risks' and 'strategic rationalisation', both of which will be outlined below.

Kinship Risks

Building on Goffman's (1963) concepts of 'courtesy stigma' and 'discredited' and 'discreditable' stigmas I introduced the concept of 'kinship risk' to explain clinicians' and recipients' conceptualisation and negotiations of acceptable and unacceptable

differences. The concept of 'kinship risk' refers to physical differences between recipients and their child that might reveal the lack of a genetic relationship between recipients and their child and consequently the child's genetic relationship with another party ('relational stigma'). 'Kinship risks' can lead to 'resemblance talk' (Becker et al., 2005), where physical differences between recipients and their child were seen as a threat to recipients parental identity, to children's belonging within the family and to family legitimacy, i.e. to displaying family.

Not all types of differences were construed as a kinship risk. In practice, clinicians and recipients appeared to conceptualise some 'kinship risks' (i.e. differences) as more acceptable than others. For example, just as 'racial resemblance' was regarded as a primary indicator of kinship resemblance and relatedness (Becker 2000; Marre and Bestard, 2007; Szkupinski-Quiroga, 2009; Thompson, 2009; Nordqvist, 2010; Hudson, 2015), 'racial difference' was simultaneously construed as a primary 'kinship risk' by all recipients. Whilst BME recipients did not see hair colour and eye colour as an essential part of their preferences for a 'racially matched' donor some white recipients did; furthermore whilst white recipients did not see hair colour in general as an indicator of kinship they singled out red hair as a 'kinship risk'.

Goffman's (1963) concepts of 'discreditable' and 'discredited' stigmas were elaborated upon here to explain how recipients navigated their selection of donors. Recipients saw some differences in their donor as acceptable, i.e. as a 'discreditable kinship risk', in that they could be mediated, concealed or rationalised, but saw other differences as unacceptable, i.e. 'discredited kinship risks', because they were obvious and could not be concealed. When accepting donors with different characteristics to their own, i.e. 'discreditable kinship risks', recipients used a range of rationalising discourses to mediate, minimise, legitimise and accept differences. However, recipients saw donors with particular marginalised characteristics as a '*discredited*

kinship risk' which they could not mediate and so systematically excluded from their preferences and practices of donor selection through a discourse of risk.

In this study clinicians' and recipients' views of 'racial difference' were coherent; in different circumstances, both clinicians and recipients saw 'race' as both an immutable and flexible category. However, this coherency was unpinned by an underlying logic of a racial hierarchy of skin tone. That is, for white recipients, 'racial boundaries' were regarded as an immutable and fixed category grounded in naturalistic assumptions whilst for BME recipients 'racial boundaries' were regarded as a flexible and contingent category, to different degrees. Thus for white recipients 'racial difference' was conceived of as a 'discredited kinship risk' which could not be mediated whilst for BME recipients 'racial difference' was construed as a 'discreditable kinship risk', which could be rationalised and mediated.

Where clinicians and recipients did differ was in their conceptualisation of the characteristics that construed a 'kinship risk'. For clinicians, 'race' was seen as the only characteristic which posed a risk to the welfare of the child. For recipients on the other hand, stigmatised characteristics, i.e. red hair and dark skin tone, were seen as a primary 'discredited kinship risk', showing how recipients' conceptualisations of undesirability and difference were intertwined.

Strategic Naturalisation

Thompson (2001) concept of "strategic naturalisation" was built upon to explain the nuanced and complex ways in which both clinicians and recipients negotiated articulations of resemblance and difference to meet their own context-specific aims. "Strategic naturalisation" refers to the ways in which women exercise agency in the clinical context of egg donation by 'claiming or disowning bonds of ancestry and descent, blood and genes, nation and ethnicity' to suit their individual strategies of

parenthood; certain basis of kinship differentiation are foregrounded and recrafted whilst others are minimised (Thompson 2001; 2005: 149). The term ‘strategic rationalisation’ was employed to highlight the varied discourses that recipients strategically drew on to meet their aims, in which they foregrounded, minimised, naturalised, de-naturalised and re-naturalised the importance attached to different elements of the matching process.

In this study, recipients strategically rationalised the importance they attached to genetic inheritance, resemblance as an indicator of kinship, difference as a ‘kinship risk’, the welfare and well-being of the child, contextual constraints, the need to compromise and trust when seeking to make ‘acceptable’ families through matching (socially acceptable and acceptable to themselves). The ‘dynamic co-ordination’ of these various elements of the social, political, self, kinship, techno-scientific, regulatory, moral and medicalised aspects of matching illustrate the ‘ontological choreography’ (Thompson, 2005) of matching, which seeks to reproduce particular types of families (not just ‘suitable’ children and parents).

Recipients had to manage multiple identities when negotiating their access to donors, including that of a consumer, patient and parent (Thompson, 2005). When stating their preferences for donor characteristics recipients foregrounded the importance of resemblance as an indicator of kinship and the role of genetic inheritances. When accepting donors with different characteristics to their own recipients minimised the role of resemblance and foregrounded the importance time and a shortage of donors. Recipients strategically used a range of discourses to accept these donors, including drawing on: fatalistic discourses; the presence and absence of resemblance in families; alternative discourses of genetic inheritance; and trust in clinicians. When declining donors, recipients foregrounded donors’ marginalised characteristics as their

Master Status and minimised the importance of time or the desirability of donors' other attributes.

Like recipients, clinicians embodied multiple identities including that of a medical professional and an employee in a privatised context, meaning that they had a mandatory duty to provide patient information, obtain informed consent and ensure patient safety, show appropriate customer service and ensure that recipients accepted donors so that the egg donation programme could keep running. When matching donors and recipients clinicians strategically drew on different discourses to rationalise the types of matches they wanted to make. Clinicians' classification of patients' characteristics illustrated how clinicians foregrounded their own perceptions of skin tone and genetic inheritance to categorise individuals into different 'ethnic' categories and to 'mark' the ethnic classification of some patients (particularly white and mixed ethnicity patients).

When allocating donors to recipients clinicians foregrounded medicalised characteristics and 'race' as protecting the medical and social welfare of the child. However, a shortage of BME donors (in particular) meant that both of these primary matching criteria were seen as negotiable for BME recipients and not seen as an overriding welfare of the child concern. Furthermore, such strategic rationalisations followed a racialised hierarchy of skin tone whereby clinicians were more likely to allocate 'marked white' donors to BME recipients – thus foregrounding their 'markedness' over their 'whiteness' and to match these donors with South Asian recipients over black African/Caribbean recipients. However, clinicians ideally wanted to avoid allocating 'marked white' donors to white British recipients and took steps to strategically 'unmark' donors' 'whiteness' in order to make such matches.

9.3.3 Stratified (Bio)Medicalisation and Stratified Reproduction

The concept of stratified (bio)medicalisation is still in its infancy compared to the concept of stratified reproduction (which is itself still being continually (re)developed). As highlighted by Herzig (2015: 83), “the concept of “stratified biomedicalization” on its own does not offer much in terms of delineating the processes of mechanisms of stratification”. This critique has also been recognised by Clarke et al., (2010) themselves, who acknowledge that the process of racialisation and its relationship to (bio)medicalisation and stratification has not been well-developed in their own theorisation (hence presenting the contribution to ‘racial’ inequalities here). Furthermore, despite Clarke et al., (2010) intention for the concept of ‘stratified (bio)medicalisation’ to go beyond ‘inability to pay’ the authors primarily shape this concept around neo-liberal consumerism and access to healthcare.

The concept of ‘stratified reproduction’ refers to the power relations by which individual categories of peoples’ reproductive futures are valued and empowered or despised and disempowered (Ginsburg and Rapp, 1995b: 3). In common applications of ‘stratified reproduction’ to *egg donation* the main focuses in the literature have been on the class and ‘racial’ divisions shaping women’s differential access to reproduction through ARTs (Roberts, 1999; Culley et al., 2009; Greil et al., 2011; Bell, 2016) and in determining who benefit from egg donation (recipients) and who provide the means for those benefits (donors) and their respective experiences of reproduction, particularly in contexts of transnational reproduction (Nahman, 2006; Deomampo, 2016; Whittaker and Speier, 2010; Twine, 2015). Typically, scholars of stratified reproduction in ARTS have emphasised women’s differential access to ARTs based on wider axis of inequality, e.g. class, sexuality and racialised divisions (Ginsburg and Rapp, 1955; Roberts, 1999; Mamo, 2007; Inhorn et al., 2009; Greil et al., 2011).

Whilst the concept of ‘stratified reproduction’ has been applied to areas of genetic, social, natural and assisted reproduction, the concept of stratified (bio)medicalisation is specifically intended for contexts of healthcare. These concepts converge in the context of ARTs, where the stratification of one’s access to treatment is synonymous with the stratification of one’s access to reproduction. Both concepts highlight biomedicine as a site for the reproduction and intensification of wider inequalities in society according to divisions of ‘race’, class, gender (Ginsburg and Rapp, 1995b; Clarke et al., 2010). In this respect, ARTs have been described as a “prime example” of each of these concepts (Ginsburg and Rapp, 1995b; Inhorn and Fakih, 2006; Inhorn and Birenbaum-Carmeli, 2008; Clarke et al., 2010). Previous studies which have employed these concepts in ARTs have predominantly focused on neo-liberal commercialised contexts of ARTs and explored the ways in which stratification takes place through the commodification of reproduction (Colen, 1986; Clarke et al., 2010).

This study contributes to the development of the concept of ‘stratified (bio)medicalisation’ in a number of ways. In contrast to existing scholarship this study did not focus on the type of women that are seen as legitimate beneficiaries of donor eggs and the type of women who are conceptualised as and reduced to being a ‘bioavailable’ resource for the reproduction of others (Cohen, 2005). Instead, this study focused on the systemic differences were found amongst recipients and amongst donors according to historic and social patterns of stratification, e.g. class, ‘race’ and other divisions of marginalisation, stigmatisation, inequality and discrimination.

Unlike previous studies on stratified reproduction which have predominantly taken place in transnational and international contexts of ARTs (Colen, 1986; Whitakker and Speier, 2010; Bergmann, 2011; Nahman, 2011; Daniels and Heidt-Forsythe, 2012; Kroløkke 2014; Deomampo, 2016; Schurr, 2016) and/or have focused on the experiences of middle-class white women as users of gamete donation (Konrad, 2005;

Mamo; 2005; Bonaccorso, 2009; Nordqvist, 2010; Klotz, 2014; Rubin et al. 2015), this study is situated in the UK and contributes to growing literature on the experiences of BME women from working-class backgrounds (Roberts, 1999; Inhorn and Fakih, 2006; Inhorn et al., 2009; Culley and Hudson, 2009b; Szkupinski-Quiroga, 2007). This study explored on how stratification takes place within a predominantly medicalised context of reproduction, rather than merely a commercialised context, and showed how stratification can take place at the level of the individual and family. Unlike current literature on stratified reproduction and (bio)medicalisation this study concentrated on recipients' access to reproduction by virtue of their access to donors, rather than their access the clinic, which was predominantly commercialised. Thus attention was paid to how recipients' access to donors was shaped by ideological, structural and contextual constraints, not just economic constraints.

According to Clarke et al., (2010), "stratified biomedicalization" can occur when clinicians classify patients as 'good/deserving' or 'bad/undeserving'. Echoing previous studies this study found that clinicians' classification of patients as 'good' or 'bad' shaped recipients access to treatment (Doyal, 1987, Pennings, 2001 Haimes, 1992; Price, 1997; Steinberg, 1997; Roberts, 1999, Malin, 2003) by virtue of their access to donors. In this study, clinicians undertook strategies to 'normalise' the behaviour of 'demanding' recipients who posed a threat to their own authority, e.g. they avoided matched these recipients or referred them to counselling before allowing them to proceed with treatment, thus delaying their access to treatment and encouraging them to be more compliant in the future.

Focusing on epidemiological classifications of heart disease, Shim (2010: 225) argued that "biomedicalization is stratified because of the *specific inclusion* of racial difference (from the normative "white" category") as an object requiring biomedical attention". She argues that stratified (bio)medicalisation occurs when 'race' becomes

rearticulated as a marker of risk, as something potentially pathological, thus needing to be targeted for intervention. This study illustrated how in the context of matching in egg donation clinicians conceptualised ‘race’ as a primary marker of risk, i.e. risk to kinship resemblance and the welfare of the child and as needing intervention by clinicians. Welfare of the child discourse was central to clinicians’ legitimisation of their role in matching and in protecting normative racialised kinship boundaries.

According to Rapp (2004: 311), ‘stratified reproduction is reproducing far more than individual babies: It is a lens through which we can see how representations of parenting, gender relations, and collective and familial aspirations for the next generation are also being reproduced’. For example, in their study on BME women’s Inhorn et al. (2009: 182) show how a wider prejudice towards the ‘*unwantedness* of more black and brown babies’ is part of the barriers faced by BME recipients in accessing fertility services. Drawing on Rapp’s (2004) attention to “collective and familial” reproductive futures this study contributes to the concept of ‘stratified reproduction’ by showing that stratification can take place according to *collective* and *relational* categories of reproductive futures, i.e. of families, not just *individual* categories, i.e. children and parents.

In this respect, it wasn’t the reproduction of particular individuals that was ‘valued’ or ‘despised’ through perceptions and practices of matching but the reproduction of particular types of families. That is, ‘racially congruent’ families were ‘valued’ and empowered for reproduction whilst racially incongruent families (Wade, 2012) were ‘devalued’ and discouraged from being reproduced and subject to disciplinary/exclusionary (bio)medicalisation. For example, recipients who specifically requested a donor of a different ‘race’ were pathologised as ‘anxious patients’ and would be subject to disciplinary measures (e.g. counselling).

The imposition of 'racial matching' had particular consequences for BME recipients' access to donors, whereby a shortage of BME donors meant that these recipients often waited longer than their white counterparts for a 'racial match' and were expected to compromise on their preference for an 'ethically matched' donor and be willing to accept a white donor. Whilst 'racial matching' epitomised 'stratified (bio)medicalisation' and 'stratified reproduction' far more revealing was the nuanced ways in which stratification took place through discourses and practices of 'transracial matching', which revealed the nuances of recipients' heterogenous access to donors based on racialised skin tone.

Firstly, whilst clinicians saw it as acceptable for BME recipients to access a different 'race' they saw it as unacceptable for white recipients to access a BME donor. Secondly, the reproduction and (bio)medicalisation of BME recipients was stratified differently amongst recipients from different minority ethnic groups; whilst it was seen as acceptable for a South Asian recipients to access a white donor this was not equally the case for black African/Caribbean recipients. Even then, clinicians' typically left South Asian recipients waiting longer for a white donor than their white counterparts (e.g. by ignoring their position on the waiting list).

Furthermore, the acceptability of matching a white donor with a South Asian recipient depended on recipients' skin tone, the skin tone of their partner and the skin tone of that white donor making their access to such donors was stratified in multiple ways. Although on the whole clinicians and recipients shared similar views about the types of matches that should or should not be made it is important to bear in mind that the imposition of such matching criteria by clinicians imposed restrictions on recipients' access to donors. Thus whilst on the surface 'transracial matching' appeared to challenge a racialised ideology of the family these racialised boundaries were still negotiated according to existing racialised hierarchies of skin tone.

Unlike previous studies, which have argued that there is a “reproduction of whiteness” through egg donation by predominantly focusing on the reproduction of white recipients and white donors (Roberts, 1999; Szkupinski-Quiroga, 2007; Cooper and Waldby 2014; Kroløkke, 2014; Deomampo, 2015; Schurr, 2016; Homanen, 2018), this study has shown how whiteness was reproduced through clinicians’ nuanced discourses and practices of ‘transracial matching’ with recipients from diverse ‘racial’ backgrounds. That is, for white British recipients, clinicians saw it as their responsibility to maintain and reproduce ‘whiteness’ through ‘racial matching’ whilst for BME recipients clinicians sought to restrict ‘whiteness’ by matching recipients according to a racialised hierarchy of skin tone and limiting their access to ‘marked white’ donors. This contribution extends the ‘reproduction of whiteness’ to go beyond the reproduction of white babies and non-reproduction of BME babies (Inhorn et al., 2009) to show the complexities of how whiteness was protected rather than merely reproduced.

This study also showed how other patterns prejudices and axis of inequality in wider society were reproduced in the clinic (aside from racialisation) and their implications for stratified the reproduction of donors. Recipients’ systematic exclusion of donors with marginalised characteristics reproduced wider inequalities in society within the clinic and stratified reproduction in multi-layered ways. Whilst recipients’ exclusion of donors with darker skin tone than themselves has been documented (Nahman, 2006) this study also showed how the *genetic* reproduction of donors with other marginalised attributes, i.e. red hair, a high BMI and who identified as Muslim or lesbian, was also devalued and discouraged.

The systematic nature of such stratifications was revealed from recipients’ preferences and practices of exclusion and took place through discourses of risk and strategic rationalisation. The exclusion of egg sharing donors in particular translated into

another layer of stratified reproduction in which their access to their own reproduction (through ARTs) was dependent upon being accepted by a recipient.

Studies in some contexts of egg donation, such as the USA and India, have highlighted the stratification of reproduction through the differential valuation and payment to donors according to a hierarchy of desirable characteristics (Almeling, 2011; Deomampo, 2016). In the UK however, the payment of donors is regulated and restricted. Thus although clinicians and recipients valued and de-valued different types of donors in different ways this was not reflected in the payment to donors but through their practices of inclusion and exclusion. Recipients did have consumerist preferences and display consumerist practices in declining donors. However, the nature of this consumption was different to that of the rational autonomous consumer (Lupton, 1997) and was embedded in constraints.

The recipients in this study did not specifically select donors with socially desirable characteristics, as they did in other studies, as there was limited scope to do so in their preferences and their choices were constrained by the donors they were allocated. Rather, they excluded donors with socially marginalised/stigmatised characteristics from their reproduction. Recipients did not draw on discourses of desirability and consumerism to legitimise excluding donors but on discourses medicalisation, risk and trust. Although a nuanced distinction this difference reflects the nature of consumerism as it might apply to the UK compared with some other countries.

9.3.4 (Bio)Medicalisation and The Reification of 'Race'

This study contributes to medical sociology's understanding of the ways in which 'race' and ethnicity are conceptualised and operationalised in the predominantly privatised biomedical context of egg donation, including how medical professionals

classified 'ethnicity' and skin tone, the meanings that clinicians and recipients attached to 'ethnicity' and how resources were allocated differentially according to racialised categories of ethnicity. These contributions will be outlined below. The intersections between 'race', ethnicity and stratification were explored above.

According to Gilroy (2000a) the 'old' reproduction of 'race' and the nature of identities have been transformed by scientific and technological developments, such as molecular biology and body imaging. Gilroy (2000a: 43) argues that such developments are a "compelling sign that we have begun to let the old visual signatures of "race" go". Contrary to Gilroy's thesis, the findings of this study echo those of scholars who argue that 'race' has become reified and reproduced through techno-scientific developments, through which sophisticated technologies are employed based on old classificatory regimes (Collins, 1999; Duster, 1990; 2005; Rabinow and Rose, 2006; M'Charek, 2008), including in gamete donation (Roberts, 1999; Fogg-Davis, 2001; Fuscaldo, 2006; Szkupinski-Quiroga, 2007; Thompson, 2009; Nordqvist, 2010; Deomampo, 2015; Hudson, 2015).

This study showed how 'race' was reified and reproduced through the different stages of the matching process and through the everyday perceptions, tools, interactions and material practices of clinicians and recipients (Thompson, 2009; Nahman, 2006; Deomampo, 2016). Ethnicity was typically conflated with 'race' by recipients and clinicians and treated as if it was a proxy for physical characteristics (particularly skin tone) and a genetically inheritable characteristic. Clinicians' definition and classification of ethnicity took precedence over patients' self-identified ethnicity and their classification of ethnicity was inherently related to clinicians' perceptions of recipients' skin tone. Clinicians' practices of classification revealed inconsistencies in the process classification as well as the conceptual conflation of "race" and "ethnicity" (Sheldon and Parker 1992; Smaje 1996; Hall 2006).

'Race' was also reified through clinicians' and recipients' nuanced discourses and practices of 'racial matching' and navigations of 'transracial matching' in which 'ethnicity' was regarded as a genetically inheritable a proxy for skin tone, i.e. as 'race'. In different contexts, 'ethnicity', or rather 'race', was conceptualised as both a flexible and immutable category. On the whole, 'race' was conceptualised as an immutable and ridged category for white British recipients' reproduction but was seen as flexible and able to be transgressed for BME recipients' reproduction, to an extent. 'Racial geographies of desirability' (Nahman, 2006) were apparent in recipients' preferences for donor characteristics, whereby recipients to exclude 'racially matched' donors according to Euro-American ideals of beauty, i.e. with darker skin tone, red hair and a high BMI.

However, unlike scholars who have argued that 'race' is geneticised through matching and turned into a "commodity" in egg donation and marketed to recipients by fertility providers (Duster, 1990; Campbell, 2007; Costa, 2007; Schurr, 2016) the findings of this study illustrated the ways in which 'race' was predominantly conceptualised as a 'kinship risk' and as a threat to the welfare of the child. Thus racialised hierarchies were reproduced through discourses of medicalisation, risk, self-surveillance, morality and naturalness, rather than *just* the market.

Clinicians' view of recipients wanting a donor from a different 'racial' background also revealed the nuanced ways in which racialised ideologies intersected with cultural ideologies of beauty, power and desirability whereby white recipients' preference for a BME donor was conceptualised as 'exotifying' whilst BME recipients preference for a white donor was seen as 'enhancing' (Nahman, 2006; Bergman, 2015; Deomampo, 2016). The different concerns of white recipients and BME recipients in having a mixed race child also reflected the intersections between gender, 'race' and reproduction, where white women were more concerned about the

risk to perceptions of their partner's paternity and their own infidelity than their status as mothers.

Marked Whiteness

In the literature, 'whiteness' has traditionally been posited as an invisible, unmarked category and as representing the 'norm' (Frankenberg, 2001) whilst 'non-white' and BME groups have been posited as visible, stigmatised and marked (Frankenberg, 1994; Jackson, 1998, Tyler, 2007; Hudson, 2015). Scholars who have argued that 'whiteness' is also marked have typically emphasised the foregrounding of whiteness as a cultural identity and the social location from which it is perceived (Erikson, 1995; Frankenberg, 2001; Snyder, 2015). The findings of this study revealed that whiteness can also be phenotypically 'marked' and 'unmarked' at different times and the consequences of this for the types of matches that could be made.

This phenotypical distinction between types of white donors echoes the findings of studies undertaken outside of the UK context, typically in transnational contexts of egg donation (Nahman, 2006; Bergmann, 2011, 2015; Kroløkke 2014; Schurr, 2016; Homanen, 2018); however, none of these have employed the term 'marked whiteness' in their analysis. As highlighted by Bergmann (2015: 236): "Whiteness is not such a stable form, it is rather a performative category alternating between different shades of whiteness as pale, sun-tanned, Caucasian or even Mediterranean".

Utilising the concept of 'marked whiteness', this study showed how at different stages of the matching process both clinicians and recipients distinguished between 'types' of white donors and consequently some white donors were seen as more suitable than others for 'racial matching' or 'transracial matching'. This finding was situated in the UK context of egg donation in which the majority of recipients and donors are white British. In this context clinicians conceptualised 'natural' white skin tone as light/fair

and saw darker white skin tone as needing to be marked. ‘Mediterranean type patients’ (white patients with darker skin tone) epitomised the concept of ‘marked whiteness’ and were labelled – and literally marked- with additional information about their ‘ethnicity’, skin tone, nationality, ancestry or place of birth. This ‘marking’ was a mechanism for differentiating between types of white donors and recipients and was shaped by clinicians’ perceptions of ‘natural white’ skin tone in the context of the UK and the categories available for classification.

The use of ‘marked white’ donors in donor allocation also revealed the flexibility of this racialised category and the different circumstances in which clinicians and recipients foregrounded the ‘marked’ or ‘whiteness’ of these donors to meet their own needs. When matching ‘marked white’ donors to BME recipients clinicians foregrounded donors’ ‘marked’ attributes in making this match acceptable but when matching ‘marked white’ donors with white British recipients clinicians foregrounded donors’ ‘whiteness’ and strategically *unmarked* the ‘whiteness’ of donors. Recipients also distinguished between types of white donors that they saw as acceptable. Some white British recipients excluded ‘marked white’ donors whilst South Asian recipients limited their inclusion of white donors to ‘marked white’ donors with darker features. The concept of ‘marked whiteness’ therefore shows how ‘race’ might be conceptualised as a flexible category whilst still being enacted according to a wider racialised logic.

9.4 Research Implications for Policy, Practice, Future Research and Study Limitations

9.4.1 Recommendations for Policy

This study was undertaken during a period of absence of HFEA policy on matching. After fieldwork had finished the HFEA introduced general guidance advising clinicians that they were not required to match the ‘ethnicity’ of donors and recipients. Whilst this general guidance is preferable to the previous prescriptive guidance the HFEA should consider the how this policy shapes clinicians’ practices and whether recipients are satisfied with the matching process.

Clinicians, recipients, donor-conceived persons, the HFEA and the State should respectively and collectively consider the meaning and values that each party attaches to the ‘welfare of the child’ and its relationship with matching. Whilst it is recognised that prescriptive guidance is perhaps not the way forward, especially given the culmination of previous HFEA policy on matching into what has been described as ‘state sponsored racism’ (Campbell, 2007), there is also a danger in leaving matching solely to the discretion of clinicians and to their own subjective moral codes.

The HFEA currently does not publish figures on the ‘ethnicity’ of patients and recipients as a standard reporting characteristic although it has published some data on the ‘ethnicity’ of donors (HFEA, 2014b). For example, when reporting statistics for ARTs the HFEA includes the age, partner status, sexuality and funding method of patients but not ‘ethnicity’ (e.g. HFEA, 2014b, 2018). This lack of nationally collected data on the usage of ARTs by ‘ethnicity’ is unfortunate as it means that evidence of the disparities in access to ARTs are only reflected in the academic works which address the ‘research lacuna’ of studies on ‘ethnicity’ and ARTs in the UK (Culley et al., 2009; Hudson and Culley, 2014).

The HFEA provides clinics with a list of ethnic codes and skin tone categories by which to classify patients (in their prescribed Donor Information Form and guidance on how to complete this form). However, it might also be useful for the HFEA to provide clinics with some guidance on the nature of their use or on navigating the complexities of their operationalisation. Although information about donors' skin tone was valued by both clinicians and recipients the ways in which its use reinforced racialised hierarchies and prejudice warrants consideration about how useful it is in practice, especially given the contentious and dubious nature of skin tone inheritance.

Although the HFEA mandates that clinicians consider how the Equalities Act (2010) might affect conditions that donors may put on their donation, it does not mandate that clinicians take these protected, and other stigmatised, characteristics into account in relation to recipients' practices of selecting donors or their own practices of allocating donors to recipients. Recipients' discriminatory exclusion of donors with marginalised characteristics contravened the Equalities Act (2010), in both letter and spirit and replicated inequalities in wider society within the clinic. Given that recipients' exclusion of donors was based on ingrained prejudices in wider society it is difficult to recommend how their perceptions might be modified directly in relation to this behaviour, particularly in this privatised context of reproduction.

Educating recipients about the complexities of genetic inheritability and the altruistic nature of donation might mediate some of their anxieties about accepting donors with socially marginalised characteristics. Counselling might play a role in this regards although it should not be used in a disciplinary way. The HFEA Code of Practice requires clinicians to inform recipients about "genetic inheritance and, in particular, the likelihood of inheriting physical characteristics from the donor" (HFEA, 2014a: 20.1(b)) which could be elaborated to address recipients' prejudices. The HFEA could also remind clinicians of their legal responsibilities in this area by linking the

Equalities Act (2010) with clinicians' role in sanctioning recipients' preferences. Clinicians might also be more aware of the type of information that they record about donors and how they relay this to recipients. Perhaps training in unconscious bias for clinicians might better equip them to recognise and address recipients' discriminatory behaviour.

9.4.2 Recommendations for Practice

Reflexivity in 'ethnic' classification

The problematic history of classifying 'race' in science and medicine, particularly in relation to the political history of reproduction (Roberts, 1999; Thompson, 2006, 2009; Szkupinski-Quiroga, 2007; Hudson, 2015) necessitates that clinicians continue to be vigilant and reflexive about the use of 'race' and 'racial categories' within the context of matching in egg donation (Fogg-Davis, 2001, Fox, 2008).

In this study clinicians' classification of 'ethnicity' revealed an inherent racialised bias whereby patients were ascribed to 'ethnic' categories based on clinicians' perceptions of their skin tone. Although the need for clinics to have the ability to classify patients from a diverse range of ethnic backgrounds is essential they should be aware of the contentious nature of these categories and how unreflexively using them inherently perpetuates stereotypes, stigma and discrimination. For example, categories ascribed to patients by clinicians such as 'Asian', 'black' and 'Oriental' have little bearing to ethnicity and reinforce racialised classifications, as does the classification of mixed ethnicity individuals to their BME ethnicity.

Despite the HFEA recommending that clinics use the ethnic categories available in the 2001 Census the clinics in this study still used the categories listed in the 1991 Census which had a restricted number of options and did not include a category for

‘mixed ethnicity’. In light of clinicians’ inconsistent use of ethnic categories and it is recommended that clinicians use the HFEA recommended ethnic codes to classify ‘ethnicity’ for consistency and validity.

Perhaps another method of classification would be to enable donors and recipients to self-identify their ‘ethnicity’ and physical characteristics as free text thus enabling recipients to receive information directly from donors without the mediation of clinicians. This is recommended practice for ethnic classification, would remove clinicians’ bias in categorisation and enable donors more agency. However, this method might make it difficult for clinicians to match donors and recipients (according to a large array of categories).

The contradictions and connotations around ‘racial’ and ‘ethnic’ categories and terminology in clinical practice are not isolated; they exist across the political, public and private spectrum, including academia. The ambiguity in navigating these contentious concepts is also illustrated in this thesis where it was sometimes difficult to walk the fine line between representing participants’ views, locating these within a wider historical and socio-political context and using language, which did not reinforce the construct of ‘race’ whilst trying to grasp its very real consequences.

This difficulty is symptomatic of underlying confusion and contradictions in the nature of these categories more generally. Nonetheless, such contradictions need to be unravelled and addressed, a first step towards which would be the acknowledgement of their existence. Perhaps in the clinical context a starting point would be to educate clinicians about the historical and political nature of ‘race’ and racialised categories, the nature of ethnic diversity and inequalities and about genetic heritability and population genetics.

Responsiveness to recipients' need for donor information

Following recent studies (Stuart-Smith et al., 2012; Rubin et al., 2015; Zadeh et al., 2016b), it is important for clinicians to consider the amount and type of donor information that individual recipients may or may not want. Whilst many recipients felt that the amount of donor information they were given was not enough they also had concerns about having more. Clinicians should perhaps approach this on a case-by-case basis, and be aware of some recipients' need for more, or less, information than provided on the standard clinic forms.

Clinicians should be reflexive about the information they record about donors, how it is relayed to recipients and the implications of this information for recipients, donor-conceived persons and their own matching practices. In this study, recipients were more satisfied with donors being offered in a face-to-face consultation than via e-mail, and this method appeared to help their process of acceptance.

Awareness of the importance of trust

Trust was illustrated as being central to recipients' decision to accept or decline donors at each clinic. Recipients' relationship with clinicians was a central feature of their degree of trust in clinicians. Clinicians should be aware of how their relationship with recipients might impact recipients' behaviours and should not assume that recipients who decline donors are overly anxious and need to be managed. Instead, they could focus on the role of trust in recipients' decision-making and accept that recipients may simply be unhappy with their choice of donor.

Recipients trust in clinicians was associated with a higher rate of acceptance whilst a lack of trust in clinicians was associated with a higher rate of declining. Clinicians should take time to understand the nature of recipients' 'non-compliant' behaviour and see how they might help to address recipients' concerns. They should consider the

role of counselling in the clinic and whether it is always the best intervention for recipients who do not comply with clinicians' expectations. Rather, clinicians' could be more reflective about their own expectations and the assumptions that inform them.

Clinicians' role in matching

Clinicians intertwined their mandatory responsibility to consider the 'welfare' of children born through the clinic with their role in matching. In this respect, clinicians saw 'racial difference' and 'racially incongruent' families as a threat to the social welfare of the child and drew on medicalised criteria as harmful to the medical welfare of the child. Whilst clinicians' commitment to the welfare of the child is commendable (especially in the context of the UK, in which this notion is given primacy in law), there is no evidence base for matching by height/weight or CMV status in egg donation. Neither is there an evidence base for 'racial matching'. Clinicians drew on their own moralised concerns about 'transracial matching' and these concerns played out in their practices.

That is, only certain types of matches were being made in the clinic, with the consequence that only certain types of families were being reproduced. When allocating donors to recipients it was typical for clinicians to override recipients' preferences for certain donor characteristics with their own imposed matching criteria. Perhaps if clinicians were aware of the importance that some recipients attached to their preferences, or their difficulty in coming to terms with the compromises they made (albeit in innovative ways), they might re-consider their matching priorities. Recipients' declining of donors was a prime example of the difference in how clinicians and recipients perceive a 'good match'.

The HFEA currently advises clinicians to relay information about the ‘nature of genetic inheritance’ to recipients in relation to donors’ characteristics. However, it provides little elaboration of this advice. It seems that making recipients aware of the scientific evidence on genetic inheritability might help mediate their concerns and expectations when selecting donors. However, given that clinicians are specialists in fertility medicine, not genetics, it seems perhaps unrealistic to ask them to take up this role. To help clinicians navigate their multiple roles in matching and egg donation they might receive training or expand their understanding of the difference between ‘race’ and ‘ethnicity’, ethnic inequalities, genetic inheritability of physical and social characteristics and on recipients’ experiences of having treatment.

9.4.3 Limitations

The focus of this study was narrow and concentrated on a small stage in the egg donation process, within 2 specific contexts and concentrated on the views and experiences of clinicians and recipients. As with all in-depth ethnographic studies the findings of this study were shaped by the particular context in which they took place. Therefore, they are not representative and generalisable to different contexts within and outside of the UK.

This study was based on 2 private clinics in the South East of England with particular characteristics. Thus, other clinics, in other locations, with different organisational, structural and cultural features in different locations at different times might well shape the organisation of matching in different ways and warrants further research. For example, the size, patient demographics, region of the UK, use of technology and private/NHS nature of clinics could shape how matching is organised and practiced. Because this study was a clinic-based ethnography, the experiences of recipients who

recruited their own identifiable donors outside of the clinic context were not included. In limiting the inclusion of clinics to those that recruited donors' 'in-house', this study also did not explore the organisation of matching in clinics which imported donor eggs or which partnered with other clinics in Europe.

In the time since this study began, there have been significant changes in the field. HFEA policy has changed, the state of the literature has progressed, egg freezing and the import of donor eggs from abroad has increased, many UK clinics are 'outsourcing' their egg donation programmes to clinics abroad and recipients are increasingly travelling abroad for fertility treatment. A minority of websites advertising anonymous egg donors have also emerged in the UK, although these are affiliated with individual licensed fertility clinics – not third party commercial agencies – and ultimately these clinics still sanction recipients' choices. In light of these fast-paced changes the findings of this study might provide insight into a snapshot in time of the organisation of matching rather than an indicator of the future of matching.

When designing this study I had considered including the perceptions and practices of donors in relation to matching, in addition to clinicians and recipients. However, although I recognised the central importance of donors to the egg donation process the decision was made to exclude donors for several reasons. Informed by the literature, I saw matching as predominantly undertaken by clinicians and recipients. Informed by discussions with my supervisor, I was aware of the need to limit the scope of this study to make it manageable (especially as I intended to explore multiple field sites). In light of these reasons, I thought that including donors as participants might have diluted the focus on clinicians and recipients (which was identified as gap in the existing literature) and would not have significantly contributed to an understanding of 'donor selection' (as matching was defined in the literature).

In not including donors as interviewees it is recognised that the opportunity to take a holistic approach to exploring the organisation of matching through the triad of clinicians, recipients and donors was missed and that this would have enabled important insights into the matching process and how donors were made 'bioavailable' (Cohen, 2005). Therefore the meanings that donors attached to their eggs and resemblance, how they wanted their eggs be distributed, the nature of any conditions they wanted to put on their donation, questions and concerns that they had and whether some types of recipients were seen as more acceptable than others were not included in this study (amongst other valuable insights).

My own role as a researcher could also have posed a limitation to this study. Participants' responses, actions and behaviours could have been affected by my presence, and by the presence of my own socio-demographic characteristics, e.g. age, skin tone, gender, ethnicity, sexuality, educational background. For example, several recipients presumed that I did not have fertility problems related to my age and so did not seek to make a connection with me in relation to age. However, most female recipients appeared to respond positively to my gender. My ethnicity (Indian) enabled a sense of connection with some of the BME participants in this study, including clinicians, but may also have hindered the openness of responses given by some Indian recipients (e.g. in case I knew members of their community).

9.4.4 Recommendations for future research

The large emphasis on the nature and implications of commodification and the role of the market in ARTs appear to have been at the cost of more traditional sociological analysis about medical power and how the state continues to shape reproduction in new ways.

The question of whether the UK context of egg and sperm donation can be described as a ‘medical market in donor gametes’ (Conrad and Leiter, 2004; Almeling, 2007) is an interesting one, and warrants further consideration. Particularly in the UK context, scholars researching ARTs could consider looking beyond neo-liberalism as the main backdrop for studies or draw out some of the nuances of neo-liberalism as applied to the UK. For example, consideration could be given to the specific nature of the UK politico-economic context of ARTs, in which there is a high level of state regulation, and a low – but not absent- level of state funding. Researchers might also explore how medical jurisdiction might expand in taken for granted pockets of ARTs, like the organisation of matching.

Further analysis of the relationship between consumerism and medicalisation in the UK context of ARTs would be especially welcome. The tension, relationship and connections between these two concepts has not been well theorised in the UK context of healthcare and would benefit from being explored across different sites of (bio)medicine. It would also be interesting to explore which aspects of (bio)medicalisation theory are useful for exploring the UK specific context of ARTs and which aspects of the theory might be adapted to better reflect this context.

Given the paucity of research in ARTs with BME women, researchers might consider taking a more inclusive approach when designing research and recruiting participants. In this study, the proportion of BME recipients recruited at each clinic was heavily shaped by the patient demographics at each clinic, but a concerted effort was made to recruit BME recipients (e.g. with the help of gate keepers and through building rapport). It might be helpful for researchers to be aware of, and sensitive to, specific concerns that BME women might have when participating in research in medical ART settings (e.g. given the historical relationship between medicine and ‘race’ and the highly stigmatised nature of infertility in highly pronatalist cultures).

Although individual recipients were encountered at different stages of the matching process in this study it was not possible to interview them throughout these different stages. As recipients were interviewed after having accepted a donor, they were asked about their retrospective preferences for donor characteristics. A fruitful study in the future might interview recipients at the time of stating their preferences and then again when they were matched with a donor or ‘trace’ recipients’ trajectory through the matching process. Future research which collects and contextualises statistics on the types of matches made by clinicians and recipients’ practices of accepting and declining donors (alongside qualitative methods) would also provide much needed insight into the patterns of matching practices.

Specific areas for future research:

- **The recent emergence of clinic-based websites that advertise egg donors to recipients in the UK and the ways in which clinicians and recipients interact with these websites.** Studies might explore how the roles of clinicians, recipients and the HFEA interact with, shape, and are shaped by these emerging website and their implications for reproduction. Currently, these websites are attached to licensed fertility clinics and so occupy a different place to those in unregulated contexts of egg donation, in which such websites have been explored.
- **The increasing rise in male same-sex couples and single men using egg donation**
- **The inclusion of donors as participants in addition to clinicians and recipients**

- **The impact of context on recipients' matching practices and negotiations of difference, in addition to the current more obvious focus on recipients' negotiations of resemblance and kinship.** This might include exploring how a shortage of donors, recipients' gender/sexuality and recipients' trust in clinicians shape their matching practices. It might also involve exploring recipients' experiences of managing different types of ontological identities within the matching process, i.e. being a parent, being a patient and being a consumer.
- **Comparison of the organisation of matching, and the roles of clinicians, donors and recipients, across different contexts or matching models, whether transnationally or regionally.** Studies exploring these comparisons would be useful to uncover the nuances of how context shapes the organisation of matching and what matching reveals about the peculiarities of different contexts. Future studies might also compare matching across egg and sperm donation, in which matching would be a site upon which to illuminate the specific gendered, sexualised, racialised, commodified, medicalised, technological, economic, political and stratified nature of reproduction through gamete donation.

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Appendix 1: Institutional Ethics Approval Form



Royal Holloway Ethics Approval Form

Please complete all parts of the form and the checklist. Please append consent form(s) and information sheets and any other materials in support of your application. If relevant, please also append the appropriate department-specific annex.

All applicants should refer to the Royal Holloway, University of London Research Ethics Guidelines document.

Check one box:

STAFF Project POSTGRADUATE Project UNDERGRADUATE Project

Start date: **January 2013** Duration: **1 year**. Funding Agency: **South West Academic Network (SWAN)**

Title of project: **An exploration of the meanings and practices of donor-recipient matching in UK Fertility Clinics**

Name of Researcher(s): **Priya Davda**

Name of Supervisor (Student Project): **Professor Jonathan Gabe**

Date: **14th November 2012**

Contact e-mail address: **p.davda@rhul.ac.uk**

Does your project involved NHS patients, staff and facilities? Yes No

*If your project **only** involves NHS patients, staff and facilities, you do not need to complete the rest of this form. Please send the above information, along with a copy of your initial NHS ethics application to your departmental ethics coordinator and the college ethics committee secretary. Please provide any interim communication about amendments required. Final approval by the college can only be provided once evidence of NHS approval has been provided. The researcher should provide an electronic version of the final approved NHS application, with all its attachments and a photocopy/scanned copy of the final letter of approval from the NHS ethics committee.*

Section 1

		YES	NO	N/A
1	Will you describe the main experimental procedures to participants in advance, so that they are informed about what to expect?	X		
2	Will you tell participants that their participation is voluntary?	X		
3	Will you obtain written consent for participation?	X		
4	Will you explain to participants that refusal to participate in the research will not affect their treatment or education (if relevant)?	X		
5	If the research is observational, will you ask participants for their consent to being observed?	X		
6	Will you tell participants that they may withdraw from the research at any time and for any reason?	X		
7	With questionnaires, will you give participants the option of omitting questions they do not want to answer?			X
8	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	X		
9	Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?			X

If you have ticked 'NO' to any of Q1 – 9, please give an explanation in the box below (expand as necessary):

Section 2

		YES	NO	N/A
10	Will subjects/participants be paid?		X	
11	Is electrical or other equipment to be used with subjects/participants?	X		
12	Are there any financial or other interests to the researcher(s) or department arising from this study?		X	
13	Will your project involve deliberately misleading subjects/participants in any way?		X	
14	Is there any realistic risk of any <i>subjects/participants</i> experiencing either physical or psychological distress or discomfort? If yes, describe any measures to avoid/minimise harm to subjects in the box below.	X		
15	Is there any realistic risk of <i>researchers</i> experiencing either physical or psychological distress or discomfort?		X	
16	Will the project require approval by any ethics committee outside Royal Holloway (eg NHS NRES committee)?		X	
17	Do subjects/participants fall into any of the following special groups? (see attached guidelines)	a) Children (under 16)		X
		b) Those aged 16-18		X
		b) People with learning or communication difficulties		X
		c) Patients	X	
		d) People in custody		X
	e) People engaged in illegal activities. (e.g. drug taking)		X	

If you answered 'yes' to any of questions 10-17, please provide full details in the box below (expand as necessary).

Q11. A digital tape recorder will be used to record interviews with participants. This equipment will only be used following the informed and written consent of interviewees. In order to ensure that the potential intrusion of electronic equipment is kept to a minimum, I will ensure that the voice recorder is fully charged and in working order before the interview, and I will place the recorder in an unconstructive but receptive place. Should any participant(s) choose not to have their interview electronically recorded, a digital tape recorder will not be used, and hand written notes will be made during the interview instead.

Electronic recordings collected from participants who subsequently withdraw during or on completion of the study will be erased.

Q14. Although there are few anticipated risks to participants in this study, it is recognised that experiences of infertility and undergoing fertility treatment (especially with donor gametes) can have significant and far reaching consequences for those affected, rendering them a 'vulnerable' or 'sensitive' population due to the potential detrimental effects to their psychological wellbeing, emotional relationships, physical health and finances (Shapiro and Paret, 2001). Furthermore, fertility treatment with donor gametes is an especially delicate topic, associated with a history of stigmatisation, secrecy and anonymity. Given the sensitive nature of fertility treatment, there may therefore be a possibility of some patients becoming upset or emotional about the issues raised during observation or interview. In order to pre-empt my role in this study contributing to these cases, I will ensure that all of the participants in this study are made fully aware of who I am and the nature of my study.

Q14. (continued...). I will try to remain reflexive and diligent about the period data collection and about my own presence in the research settings. Sensitivity, compassion and adaptability to participants' views and experiences will be exercised throughout the data collection period, and I will emphasis to participants that participation is entirely voluntary, that their contribution to this study will remain confidential and anonymous, and that they are free to withdraw, at any time, without any consequence to their job or treatment at the clinic. Furthermore, all patients will be provided with the details of support groups for those affected infertility issues.

As this is an overt study, all participants will be made fully aware about what the study entails and my role within the clinic. Nevertheless, it is recognised that fertility clinics are medical settings which will contain very busy and private spaces. For the practitioner, the research setting is a workplace where they must manage their time, relationships, emotions and workload. The clinic Manager in each research setting will therefore introduce the researcher to members of staff in their clinic and the researcher will subsequently explain the nature of the study and what is required from participants so that members of staff are fully informed about my role within the clinic. For patients, the research setting is a place of treatment, where they may be experiencing stressful events and interactions and in which they must manage their emotions. Appreciating the sensitive nature of fertility clinics as research settings, I will endeavour to be reflexive, unobtrusive and considerate about my presence in the fertility clinics and during my interactions with all individuals within this setting. I will also emphasis to participants that their participation in this study is voluntary and will remain entirely confidential and anonymous, and that they are welcome to ask me questions or withdraw their participation at any time during and after this study.

Given the focus of this study on donor-recipient matching practices, it is anticipated that this subject matter is not so sensitive that it will have particularly adverse effects on patients. However, during interviews it may be the case that some patients find it difficult or distressing to talk about the use of a donor whilst drawing on their experiences of infertility and fertility treatment. If this occurs, I will pause the interview and the participant will be given the option to withdraw from the study, to continue at a later time, or to carry on with the interview after they have taken a break. I will also reiterate to participants that they are free to withdraw from the study at any time, without any reason or consequence, and that their participation and contribution to this study will remain confidential and anonymous. All participants will be provided with contact information of support organisations for people who are affected by infertility and fertility treatment on the information sheet provided to them, details of which will be highlighted again. I will endeavour to remain professional and compassionate with participants throughout the undertaking of interviews and will always put the needs and rights of the participant first in any event.

Q17. C). This study will involve patients who intend to undergo fertility treatment with donor gametes (eggs and sperm), and who are specifically at the stage of selecting a donor. Only private patients attending the fertility clinics taking part in this study will be included. No NHS patients will be included in this study. Before attending the research setting, I will obtain written consent from the Manager at each participating clinic and ethical approval from an Ethics Committee at Royal Holloway, University of London. No patient identifying data will be sought in this study.

In the first instance, all patients will be identified and approached by a member of staff at the clinic. Patients will be approached by a clinician twice to enquire whether they are interested in participating in this study before I am introduced to them. Furthermore, all patients will be provided with a tailored Information Sheet before meeting the research and will be given at least 1 week to consider whether they would like to participate in this study. I will personally explain the nature of the study and what participation will involve to all participants. I will also emphasise to all participant that participation is entirely voluntary, that their involvement in this study will remain confidential and anonymous, and that they are free to withdraw at any time during the study, without any consequence to their rights or treatment at the clinic. Informed written consent will only be obtained from participants after I have answered any questions that they have and have ensured that they have understood the information provided to them.

Section 3

Please provide a description of the project using the following headings *Expand this section as necessary*

1. Title of Project:

An exploration of the meanings and practices of donor-recipient matching in egg and sperm donation in UK Fertility Clinics

2. Purpose of Project:

Aim: To explore the stage of donor-recipient matching (the selection of a particular donor for a particular patient) in UK fertility Clinics.

Objectives:

- To explore and understand the processes and practices underlying donor-recipient matching
- To understand the choices, beliefs and experiences of patients, doctors and policy-makers in donor-recipient matching practices
- To explore the meaning and use of social and physical characteristics in matching practices
- To explore the impact of policy and legislation on donor-recipient matching practices

3. Methods and measurements to be used (widely used questionnaires need not be appended, but previously unpublished questionnaires should be submitted for approval). Please provide a full list.

An ethnographic approach will be used in this study in order to explore the meanings and practices of donor-recipient matching in fertility clinics. This approach will be used in order to gain both a descriptive understanding of the processes and practices by which donors and recipients are matched by clinicians and to gain a deeper understanding of the contextualised meanings and experiences which underlie practices of matching and the use of matching characteristics. Ethnography involves gathering data from a variety of sources and using a range of methods, including observations, interviews and secondary data sources, such as documents, legislation and policy.

Ethnographic research is essentially an inductive process, where one begins with observations about the empirical world, allows categories to emerge from the raw data, and finally moves towards concepts and theories. Ethnography is a qualitative methodology, concerned with the study of socio-cultural groups, organisations, and systems in the context within which they occur. This approach therefore allows for a descriptive picture of that context and in-depth examination of its processes, meanings and phenomena. By definition, ethnographic research entails the triangulation, or mixture, of various methodological approaches. In research methodology, the notion of triangulation is based on 'the idea that looking at something from multiple points of view improves accuracy' (Neuman, 2006: 149). The adoption of an ethnographic framework will therefore permit identification of and insight into the processes which shape donor-recipient matching in practice, and enable exploration and understanding of the meanings, beliefs, assumptions and experiences which underpin this practice. The methods used in this study will consist of: observations, semi-structured in-depth interviews and the collection of secondary written documentation.

A central theme in the literature on social research methods has been to what extent issues of data credibility stemming from a positivistic paradigm can be equally applied to data being collected from an interpretivist paradigm and qualitative methods (Bryman, 1988). Qualitative researchers have argued that the transference of framework from a positivistic paradigm to an interpretivist one is not possible as the concepts of 'validity' and 'reliability' as they are understood in quantitative research designs, are inapplicable in the same manner to qualitative research designs (Yardley, 2000). For example, according to Golafshani (2003), in the qualitative paradigm reliability and validity are conceptualised in terms of trustworthiness, rigor and quality. Thus reliability in this sense may include the accuracy of transcriptions and the standardisation of analysis whilst issues of validity may include the impact of the researcher on the setting and his/her values. Researchers have therefore recommended triangulation as a possible form of validation in qualitative data collection and analysis (Silverman, 2001; Neuman, 2004; Denscombe, 2007). As discussed, triangulation will also be employed in this study. It is hoped that triangulation of observations, interviews and secondary written documentation will enable comparison of data collected from different sources, and to gain different perspectives of the research setting from these sources.

Observations

The method of 'participant observation' will be used to address the focus of the main research question on matching practices (as opposed to the meanings underpinning matching practices). Matching practices involve the processes, decision-making stages, social organisation, context and structures that influence the ways in which donor-recipient matching is undertaken. Given the lack of knowledge about clinic-mediated matching practices, I hope to address this current gap in the literature by 'mapping' the practice of donor-recipient matching and the social context within which it takes place. To achieve this aim, observations will be undertaken in 2 fertility clinics which offer treatment with donor gametes (eggs and sperm).

Data collection through observation is intended to be a primarily descriptive process, allowing the researcher to understand the phenomena they are studying within the context that it takes place, therefore enabling sight into the processes and contextual factors which shape these phenomena (Hammersley and Atkinson, 2007). Participant observation involves the researcher taking part, to various degrees, in the "daily activities, rituals, interactions and events of a group of people as one of the means of learning about the explicit and tacit aspects of their life routines and culture" (DeWalt and DeWalt, 2002: 1). It thus seeks to "uncover, make accessible, and reveal the meanings (realities) people use to make sense of their daily lives," (Jorgensen, 1989: 15), and to build a rich and detailed account of the phenomena under study. This entails viewing phenomena from the perspective of those being studied in their own settings, and involves "looking and listening... watching and asking" (Loftland and Loftland, 1984: 47) as part of the observational process.

As I am not a qualified fertility practitioner and do not have the specific training and knowledge possessed by the professionals I will observe, it is anticipated that I will be unable to fully participate in the activities of the research setting. I will nevertheless try to integrate myself within the broader structure and culture of the fertility clinics within this study. Furthermore, this 'naivety' may contribute to a less presumptuous understanding of the research context, permitting me to ask legitimate questions about the practices which might have otherwise been taken for granted as established 'givens'. I intend to take on the role of 'Moderate Participant' or of 'Participation-as-Observer', where one is identifiable as a researcher, who occasionally interacts, and generally 'shadows' a person through normal life rather than actively participating in the research setting.

Whilst the design of such observations will to a large extent be dependent on the organisation and practices of matching within each of the research contexts, such activities will include: work-shadowing relevant clinicians' day to day activities; observation of activities and team meetings where potential donor-recipient matches are negotiated or discussed; and observation of patient-clinician consultations where matching-related activities are discussed. Observation of all of these activities will only take place with the informed written consent of all participants concerned (see the section on 'Consent and participant information arrangements' below).

As an instrument of data collection in participant observation (Fielding, 2001), I will endeavour to be reflexive and systematic during observations and the writing up of field notes. Given the qualitative nature of observation, it is hoped that this will increase the validity and reliability of my observations. Where possible, field notes will be written up during the course of fieldwork, and/or as soon as possible after each period of observation. Field notes will include documentation of observations, quotations from participants, and reflections from my own personal thoughts, feelings and experiences during this phase of data collection. It is anticipated that observations will take place for up to 6 months in each research setting, for a period of 2-3 days a week. To some extent, the total amount of time spent in each clinic will depend on when theoretical saturation has been reached, i.e. when no new data are being found which develop categories or the properties of categories (Glaser and Strauss, 1967: 61). Particular attention will be given to attending the research setting during matching-related activities.

Interviews

Although observational work can tell us about how people respond in particular settings, it is unable to explain how people constitute that setting (Silverman 2001: 54). The method of in-depth interviews are often employed for this purpose, to explore complex and subtle phenomena, and to “gain insights into things like people’s opinions, feelings, emotions and experiences”, ‘sensitive issues’ and ‘privileged information’ (Denscombe (2007: 174). Thus whilst information about the processes and decision-making stages by which patients and clinicians undertake donor-recipient matching may be revealed through observations, it is only through interviews with patients and clinicians within these processes that insight can be gained into the subjective assumptions, meanings and beliefs which inform these social practices. Policy-makers will also be interviewed because of their importance in informing policy guidance and clinical practices pertaining to donor-recipient matching.

Qualitative semi-structured face-face interviews will be used rather than structured interviews or surveys because this method is the most appropriate tool to collect the type of data needed to gain understanding about the meanings attached to matching practices and matching characteristics. Unlike quantitative methods, semi-structured interviews will enable a degree of flexibility in the interview to explore any interviewee- or role-specific issues as and when these arise and to gain clarification and further understanding of participants’ responses. Face-face in-depth interviews will also enable me to build rapport with the interviewees so that they are more comfortable and feel able to express themselves honestly, thus improving the quality of the interview and the reliability of data.

Although the specific direction of the interview will inevitably depend on the position and role of the participant being interviewed, the use of a standard yet flexible topic guide will help to provide a consistent framework for interviews with patients and clinicians in each of the research settings, whilst allowing for the direction of questions to be tailored to individual participants roles and circumstances. This topic guide will also be used to interview policy-makers, although the orientation of the interview will be less focused on experiences of matching practices. The topic guide will be based on: i) issues that have been identified from a review of literature and policy, ii) previous researchers’ topic guides (as these relate to previous research done in this area) and iii) the research objectives of this study. Refinement of the topic guide may also take place according to data that emerge from the initial period of observations.

The topic guide for clinicians, patients and policy-makers will broadly cover the following issues:

- The social organisation, structure and practice of donor-recipient matching
- Beliefs and understandings about genetics and heredity
- Meanings of race/ethnicity
- Policy and Legislative issues, specifically Welfare of the Child considerations

Please see Appendix 1 for a more detailed outline of the topic guide.

Interviews will take place for approximately 1 hour and will be conducted in a quiet and private place. Interviews will only be undertaken with the informed written consent of participants (see the section below on 'Consent and participant arrangements'). Interviews will be digitally recorded (following the written permission of the interviewee) and transcribed as soon possible after the interview, along with documented recordings of my own reflections and speculations. If participants choose not to have their interview recorded, I will make hand-written notes during the interview instead. It is anticipated that most interviews will be undertaken within the clinic. However, if any interviewee requests that their interview be undertaken at their home or another convenient and quiet location, then I will endeavour to accommodate their request. If I were to conduct any interviews off the research site, then I would inform my supervisor about the details of location and arrange the interview at an appropriate time and location.

Interviews will be undertaken with patients at three different stages of the matching process (please see Appendix 2 for a diagram of patient's matching pathway). Patients in stage 1 comprise patients who have a matching consultation with a clinician booked (where their preferred donor characteristics will be discussed). These patients will have their consultation observed, followed by a semi-structured interview about their choice of donor characteristics and their experience of the consultation. Stage 2 encompasses those patients who are on the waiting list to be matched with a donor (this can take around 6 months), and who have specifically been on the waiting list for a minimum of 4 months). Patients at stage 3 consist of those who have been offered a donor match and who decide to accept or reject the offered donor. Patients at stage 2 and 3 will be interviewed about their particular experiences of the matching process and their preference of donor characteristics.

As the focus of this study is on the process and practice of matching, and on the views and experiences of patients at different stages within this process, a cross-section of patients, rather than following patients through their pathway/journey within the clinic, was thought most suitable to address this focus. Of those patients who register with the clinic, only some couples remain patients at the clinic and proceed to treatment (either because they leave the clinic or are still waiting to be matched with a donor). Thus, whilst numbers of patients who remain a patient at the clinic from stage 1 and stage 2 through to stage 3 during the course of this study may be relatively low, it is hoped that any patients who do make this progression will be interviewed again at stage 3. If undertaken, it is hoped that this second interview will enable insight into the ways in which patients' preferences of donor characteristics may change over time/according to the situation they are in, and may contribute to a more coherent and continuous picture of patient experiences and the matching process. As highlighted in the literature on research methods, there are a number of disadvantages of using interviews as a method of data collection.

The role of 'interviewer effects' or 'interviewer bias' is one of the main drawbacks of this method, referring to the ways in which participants respond differently depending on their perception of the person asking the question, predominantly according to characteristics such as the sex, age, ethnicity and class of the interviewer (Denscombe, 2007). This can affect how much information people are willing to give, and how honestly, and therefore may affect the reliability and validity of data collected. However, as noted by Denscombe (2007), all individuals have prejudices and preferences about others, and if interviews are undertaken with skill, then the interviewer and interviewee are likely to develop some rapport and trust (although this will also be influenced by the topic under discussion). Such skills may include the interviewer remaining neutral, passive, non-judgemental, attentive, sensitive and adaptable to feelings of participants

Another issue of validity in interviews is that there is no way of verifying what someone tells you. It has therefore been recommended that the accounts produced by interviewees must not be treated as 'valid in their own terms' and beyond assessment and explanation, but must instead be corroborated with other sources of data, and used as one source of information about events which reveal the perspectives and discursive practices of those who produced them. Interviews will therefore be used as one method of data collection amongst others (namely observations and the collection of secondary written sources).

14/11/2012

Documents

The collection of secondary documentation will comprise written documentation pertaining to donor-recipient matching practices. Written documents and rules are created and used in accordance with organisational routines and practices, and are underpinned by shared cultural assumptions and general understandings (Hammersley and Atkinson, 2007). Thus, understanding patterns of meaning and action can also necessitate an understanding of rules and procedures, of both an official and informal nature.

The collection of documents for analysis has the benefit of being a relatively unobtrusive method of inquiry, and can include the collection of government publications, policies, letters and memos, records of meetings and activities and institutional literature and forms. In choosing which documents to include for analysis, Flick (2006) has recommended that documentary data should be authentic, credible, representative and clear (although in qualitative analysis it is precisely a lack of clarity which can be the focus of investigation). With these recommendations in mind, legislation, policy and internal clinic documents pertaining to matching practices will be considered for inclusion in this study.

Two pieces of legislation will be included in this study, the Human Fertilization and Embryology Act 1990 and the Human Fertilization and Embryology Act 2008 (Amendment Act). Although the latter Act has now repealed the former, both will be included in order to see any differences that might have shaped present discourses pertaining to matching. Relevant Letters and Memos from the Department of Health to individual fertility clinics will also be included. Policies and literature published by the Human Fertilisation and Embryology Authority (HFEA, licensing body for fertility clinics) will also be analysed, in particular the HFEA's Codes of Practices from 1990- 2012 (all Codes of Practice). Specific attention will be given to references which focus on donor-recipient matching and Welfare of the Child considerations (as these have been inter-twined) within these documents.

Internal documentation will also be collected from participating fertility clinics. This may include template forms used to record patient and donor characteristics, anonymous records of previous donor-recipient matches according to particular physical and social characteristics, and internal clinic policies and procedures. Permission to access these documents will be sought from the clinic's Manager at each research setting. Only non-identifying patient data will be sought and included in this study, which will be identified and located by clinic staff. It is therefore not anticipated that there will be any specific ethical issues in accessing this data. Non-identifying/anonymous statistics will also be sought from each clinic in order to contribute to contextualising each of the research settings.

4. Participants: recruitment methods, number, age, gender, exclusion/inclusion criteria

Research Settings

The research setting for this study is situated within the broader field of infertility and fertility treatment in health care. This study will be undertaken in two private fertility clinics in London which offer treatment with donor eggs and donor sperm. Two research sites will be used to enable comparison of specific clinic-mediated practices of matching. A period of 6 months will be spent in each of the two participating fertility clinics (12 months in total) in order to allow sufficient time for 'immersion' in each research setting and for the data collected to be of sufficient depth.

Participants

The focus of this study on the meanings and practices of donor-recipient matching in UK fertility clinics necessitates that the sample of participants included in this study are able to contribute to exploring this aim. A purposive sampling method will therefore be used in this study in order to select participants. This will include three purposive sampling frames with different inclusion and exclusion criteria for looking at three different populations: clinicians, patients and policy-makers. The primary aim of using purposive sampling “is not so much to generate a sample that is ‘representative’ of a larger population as it is to represent certain subject characteristics that are considered relevant to the investigation” (Stommel and Willis, 2004: 302-3). Thus, the number of case studies and interviewees used are less important than the criteria used to select them (Office for National Statistics, ‘Purposive Sampling’, 01 April 2008).

A purposive sampling method is generally used when the researcher already knows something about the specific people or events that they want to study and ‘handpicks’ particular ones because they are thought to produce the most valuable data (Denscombe, 2007). That is, potential respondents are chosen according to their relevance to the topic under investigation rather than in order to be representative of a particular population. It is recognised that this method of non-probabilistic sampling may limit the extent to which findings from this study will be able to be generalised. However, given that so little is known about donor-recipient matching in the UK and because this research study is relatively small-scale (and so the numbers of participants needed for a sufficient probability sample would be difficult to achieve), a purposive sampling is thought to best suit the requirements of this research design.

Below, the sampling frames for patients, clinicians and policy-makers will be outlined. However, because the procedures for identifying and approaching potential participants is so intertwined with procedures for obtaining informed consent, I will outline the procedures for recruiting participants (including how they will be identified and approached) in the next section on ‘Consent and participant information arrangements’.

Sampling: Clinicians

Purposive sampling will be used to select clinicians to ensure that a range of experiences are represented with regards to the different stages involved in the matching process. Clinicians will be chosen according to their role in the clinic, rather than individual socio-demographic characteristics, such as age/gender/ethnicity, and to what extent they are involved in the matching process. This will include clinicians at different stages and levels of the matching process (i.e. managerial, operational and administrative). This may include clinicians whose roles include: discussing potential donor characteristics with patients; selecting potential donors; or overseeing/managing decisions within the clinic.

The number of clinicians to be interviewed will depend on the structure and organisation of each research setting. It is expected that this will consist of no more than 5 clinicians in each clinic.

Sampling: Patients

Potential patient participants will include patients at different stages of the matching process. This will include: 1) patients at the stage of discussing and selecting their preferences of donor characteristics, 2) patients who have identified their preferred donor characteristics and are awaiting a matched donor (for a minimum period of 4months) and 3) patients who have recently accepted or rejected a potential donor. Patients will also be selected according to individual socio-demographic characteristics (such as sexuality and ethnicity). Only private patients will be considered for inclusion in this study. Given the paucity of empirical studies on heterosexual couples’ and minority ethnic patients’ views of the matching process the sampling frame for patients in this study will only include heterosexual couples, around 50% of whom will be comprised of those from minority ethnic backgrounds. Whilst the difficulties and dangers of labelling and categorising minority ethnic populations and individual ethnic groups is recognised here, for the purposes of this study the term ‘minority ethnic’ will be used to denote the ‘non-white’ population as reflected in the UK Census, and will include couples in ‘inter-ethnic’ or ‘mixed race’ relationships.

Lesbian couples and single women will not be included in this study because a) previous studies on matching have focused solely on lesbian couples' perspectives of donor selection, b) the concerns and circumstances of lesbians and single women seeking a gamete donor are not the same as those of heterosexual couples, and c) the number of patient participants in this study is relatively small and so having a heterogeneous sample (of heterosexual couples, lesbians and single women) would complicate analysis of the data collected and the ability to make generalisations between cases.

It is anticipated that approximately 15 interviews will be undertaken with patients in each research setting (30 patients in total), with an equal mixture of those using sperm donation and those using egg donation. It is expected that a second interview will be undertaken with a small sample of participants who were initially interviewed at stages 1 and 2 of the matching pathway (see Appendix 2), and who have consequently been offered a potential donor and accepted/rejected that donor (stage 3). Both individuals in a couple will be invited for an interview, and will be given a choice of whether to have an interview together or separately.

Sampling: Policy Makers

Potential participants will be selected according to their role and remit in making and influencing policy and legislation (rather than according to individual socio-demographic characteristics). More specifically, it is policy-makers that have been involved in legislation and guidance relating to Welfare of the Child and donor-recipient matching considerations that will be included in this study. It is expected that up to 5 policy makers will be interviewed.

5. Consent and participant information arrangements (see checklist below). Include description of procedure for obtaining second consent where deception was involved (see guidelines).

Given the fluid nature of ethnography, obtaining consent in ethnographic research can be a 'thorny' and complex issue (Drew, Hardman and Hosp, 2007; Murchison, 2010: 61). As this is an overt study, the nature of this research and what participation entails will be made explicit to all participants before the study begins. All participants will be provided with a tailored Information Sheet in advance of their participation in this study and will be given sufficient time (1 week) to consider whether they would like to take part. All interviewees will be asked whether they are happy to have their interview recorded (both verbally and on the written consent form). If they are not, hand-written notes will be made. The procedure for obtaining informed consent from clinicians, patients and policy-makers will be outlined below. This will include a description of how potential participants will be identified and approached, and of the intertwined role of consent and participant information arrangements within this process. Fully informed written consent will be obtained from all participants in this study before they take part. All signed consent sheets will be kept separately from data collected.

Two fertility clinics have already been recruited to this study. After e-mailing the Manager at each clinic, I proceeded to meet each Manager in order to explain the purpose and data collection methods of this study. The Managers agreed for their clinics to participate in this study, and have consequently provided written agreement to this effect (please see Appendix 3 for an outline of contact with fertility clinics). I will also sign the relevant confidentiality/non-disclosure forms at each research site. Obtaining informed consent from participants will be an on-going concern in this study, rather than as static.

Clinicians

In the first instance, the Manager in each research settings will introduce me to all members of staff during their team meeting at least two weeks before data collection begins. Please see Appendix 4.0 for a flowchart of recruitment and informed consent procedures. At this team meeting, I will provide each member of staff who may potentially be observed or interviewed with a tailored participant Information Sheet (see Appendix 5.0 for a copy of the Information Sheet), and explain the purpose of the study, the nature of my role in the research setting, and what participation will involve (i.e. observations and interviews). I will emphasise that participation is entirely voluntary, and that individuals are free to withdraw at any time during the study, without any consequence to themselves or their jobs. I will emphasise to all participant that participation is entirely voluntary, that their involvement in this study will remain confidential and anonymous, and that they are free to withdraw at any time during the study, without any consequence to themselves or their job.

Participants will have 1 week to consider whether they would like to participate, after which I will attend the following staff meeting. At this staff meeting, I will answer any questions that members of staff have about the study, and after ensuring that they have understood the information provided to them and that they are still happy to participate, I will obtain written informed consent from willing members of staff at this second staff meeting. This tailored consent form will include a separate statement of consent for having their day to day activities on the ward observed and for being interviewed during the course of this study (See Appendix 5.1 for a copy of this consent form). Before undertaking any interviews with clinicians, I will remind them about the voluntary nature of participation, and gain verbal consent from them to ensure that they are still happy to participate in this study.

Patients

All patients participant will be identified and approached by a member of staff at the clinic in the first instance. As I will not have access to the personal identifying information of patients, the sampling frame for patients in this study will be explained to those members of staff who will identify potential participants. Two different methods of recruiting patient participants (and obtaining informed written consent) will be outlined below.

Patients in Stage 1: Observations and Interviews

Patients who have a matching consultation already booked with the clinic will be initially be telephoned by a member of staff at least 1 week before their appointment. Please see Appendix 6 for a flowchart of patient recruitment and informed consent arrangements for patients recruited from stage 1. A member of staff at the clinic will telephone potential patient participants to inform them about the nature of the study and what participation would entail, and to explain the role of the clinic within the study. Members of staff will be asked to emphasise to patients that their decision to participate in this study is entirely voluntary, and that this decision will not affect their treatment or rights at the clinic in any way. It will also be made clear to patients that their contributions will remain anonymous and confidential.

Patients who decline to take part on the telephone will not be contacted again. Those who show an interest in taking part will be sent a tailored participant Information Sheet from the clinic (who will have the contact details of the patients) on behalf of the researcher. Please see Appendix 7.0 for this tailored Information Sheet. A cover note from the clinic will be attached to this information explaining that this study is independent of the fertility clinic and that the information has been sent by the clinic on behalf of the researcher for the purposes of data protection. Potential participants will have at least 5 days to read the information sheet and consider whether they would like to take part. I will be present in the clinic when these patients attend their consultation, but will only be introduced to patients by the clinician after s/he has inquired whether these patients are still interested in participating in the study, i.e. to having their consultation observed, and/or being interviewed. If they are interested in participating, I will join the consultation and explain the information provided to patients on the tailored participant Information Sheet, emphasising that participation in this study is entirely voluntary, and that the decision not to participate will have no adverse consequences on their rights or treatment at the clinic.

I will also reiterate to patients that their involvement in this study is voluntary, anonymous and confidential, and that they are free to withdraw from the study at any time, without reason or repercussions. After ensuring that I have answered any questions that they have and that they have understood the information provided to them and are happy to participate I will ask them to sign a written consent form (see Appendix 7.1 for consent form). This tailored consent form includes a separate statement of consent for having their consultation observed, for being interviewed afterwards, and for being contacted for an interview again at a later date should they be offered a potential donor match by the clinic whilst this study is being undertaken. In the latter case, the clinician will advise me about when such donor matches have been offered, and accepted or rejected by the patient (this will be done with the permission of the patients concerned). I will then contact the patient via the contact details they requested 1-2 weeks after this time. Please see Appendix 8 for a flowchart of procedures of recruitment and obtaining informed consent for patients participating in a second interview.

It is anticipated that a number of months will pass in between interviewing patients in stage 1 and interviewing the same patients again in stage 3 (i.e. if they were to be offered a donor after going on the waiting list). Therefore, patients who are interviewed for a second time will be asked to sign another consent form to show that they are still happy to participate in this study and have understood the information provided to them (See Appendix 9 for consent form for second time interviewees).

Patients in Stage 2 and Stage 3: Interviews

For those patients who will only be interviewed (and not observed), a slightly different method of participant recruitment will be used, although the method of identifying and approaching patients will fundamentally remain the same as with patients in stage 1. See Appendix 10 for a flowchart of patient recruitment and informed consent procedures for recruiting patients from stages 2 and 3.

Patients in stages 2 and 3 of the matching pathway will initially be telephoned by a member of staff at the clinic who will inform them about the nature of this study, what participation would entail, and about the role of the clinic within the study. Members of staff will be asked to emphasise to patients that their decision to participate in this study is entirely voluntary, and that this decision will not affect their treatment or rights at the clinic in any way. It will also be made clear to patients that their contributions will remain anonymous and confidential. Patients who decline to take part on the telephone will not be contacted again. Those who show an interest in taking part will be sent a participant Information Sheet from the clinic (who will have the contact details of the patients) on behalf of the researcher. A tailored Information Sheet will be sent to patients in stage 2 (see Appendix 11.0). A cover note from the clinic will be attached to this information explaining that this study is independent of the fertility clinic and that the information has been posted by the clinic on behalf of the researcher for the purposes of data protection.

If potential participants would like to take part they will be requested to contact me on the details provided in the Information Sheet in order to arrange a convenient time and place for an interview. Before the interview takes place I will explain the information provided to patients on the Information Sheet and answer any questions that they have about the study. After ensuring that they have understood the information provided to them and that they are still happy to participate, I will request that they read and sign a written consent form (see Appendix 11.1 for consent form for patients recruited from stage 2). The exact same procedure will be used to recruit and obtain informed consent from patients in stage 3. However, this sample of patients will also receive a tailored participant Information Sheet (see Appendix 12.0) and consent form (See Appendix 12.1), the latter of which will include a separate statement of consent for being contacted for an interview again at a later date should they be offered a potential donor match by the clinic whilst this study is being undertaken. In these cases, the clinician will advise me about when such donor matches have been offered, and accepted or rejected by the patient (this will be done with the permission of the patients concerned). I will then contact the patient via the contact details they provide 1-2 weeks after this time.

It is anticipated that a number of months may pass in between interviewing patients in stage 2 and interviewing the same patients again in stage 3 (i.e. if they were to be offered a donor after being on the waiting list for 4 months). Therefore, patients who are interviewed for a second time will be asked to sign another consent sheet to ensure that they still understand the nature of the study, what their voluntary participation involves, and are happy to participate in this study (see Appendix 9).

Policy-Makers

Relevant policy makers will be identified and located through stakeholder organisations such as the Department of Health (DoH) and the Human Fertilisation and Embryology Authority (HFEA). In advance of undertaking an interview, I will provide all participants with a tailored participant Information Sheet (See Appendix 13.0) and outline the information contained within this, such as the purpose of the study and what participation would entail. After ensuring that policy-makers have understood the nature of the study and the purpose of the interview, and that I have answered any questions they have, they will be asked to sign a written consent form to show that they are happy to participate in this study (See Appendix 13.1 for consent form for policy-makers).

Accessing Documentation

As written documentation such as legislation and policy are in the public domain, it is not anticipated that there will be any specific ethical issues in obtaining this data. Permission to access clinics' internal documentation, such as internal policies and procedures, template forms and anonymous statistics will be sought from the clinic's Manager at each research setting and identified by a member of staff. As the collection of documentation will not contain any identifying or personal information about patients it is not anticipated that any specific ethical issues in terms of consent will arise. A form of non-disclosure will be signed at each research site.

6. Nature of data to be collected (including a description of any sensitive data)

The data collected will be predominantly of a qualitative, ethnographic nature. Unlike quantitative methods which obtain numerical, quantitative data, the purpose of qualitative data is predominantly of an exploratory and in-depth nature. Data will be collected through the methods of observations, interviews and secondary documentation. The nature of data to be collected from these methods will outlined below.

All participants and interviewees will be assured that their identity and contributions to this study will be kept anonymous and confidential. All identifying data in this study will be made anonymous, so that individual participants will be unable to be identified from either raw data or analysis. The names of participants and any potentially identifying information will be changed or removed from any field notes, transcript interviews, and data analysis/dissemination. All participants will be assigned a code or pseudonym (for the purposes of analysis), and the list of names corresponding to these codes will be kept securely and separately from the data. Only the researcher will have access to this list.

Any direct quotations from participants in the recording, analysis, write up and dissemination of this study will only be presented using participant codes or pseudonyms. I will be thorough and reflective about the use and removal of identifying information about participants, and will not include any quotations that might directly or potentially identify an individual. If any participant decides to withdraw from this study, at any time, observations/interviews pertaining to those individuals will be stopped, and any data collected as a result of their participation will be erased/destroyed.

Observations

The data collected from the period of observations will consist of hand-written field notes of: the observed research context; activities and interactions within the clinic; participant quotations; and self-documented reflections of my own thoughts and feelings during the period of observation. It might be the case, during observation of team meetings for example, that I hear identifying and personal information about patients who are discussed amongst staff. If this was to occur, I would keep this information private and confidential, and not include this personal data in any of my documented field notes or reflections.

Interviews

Data collected from the method of interviews will consist of transcribed digital recordings of participant interviews of approximately 1 hour. My own personal reflections of individual interviews will also be documented. All interviews will be transcribed and any participant identifying information will be kept anonymous. Pseudonyms will be attached to individual transcripts rather than participant identifying information, and any participant identifying information will be kept separate from the raw data.

Documents

The collection of secondary written data will include statutory legislation and HFEA policy/guidance, and individual participating clinics' written policies/procedures, template forms and anonymous patient statistics. Any statistics and written documentation that are collected from participating clinics will be identified and obtained by a member of staff, so that any potentially sensitive or patient identifying information will first be screened out by staff.

7. Possible benefits/risks to subjects/participants of taking part in this research

In this section, the possible benefits *and* risks to participants in this study will be highlighted. There are very few anticipated risks to participants taking part in this study. Potential risks which may arise during this study and how they might be mitigated have been discussed throughout this ethics submission. In particular, issues pertaining to observations in busy work and medical settings, the sensitive and emotive nature of fertility treatment and participant anonymity and confidentiality have been deliberated. All patient participants in this study will be provided with contact information for groups which offer support to those affected by fertility issues in the Information Sheet. The overbearing concern with any decisions that are made in this study will be to ensure that the autonomy, dignity and safety of all participants are respected at every stage of this research.

There are few anticipated direct benefits of this study to the participants taking part. However, as little is known about donor-recipient matching practices in the UK, the findings from this study may allow insight into the practices by which donor gametes are allocated to patients and the meanings and assumptions that are attached to the use of a donor's physical and social characteristics (which are used to match patients and donors). The current variability in matching practices as a mechanism of gamete allocation has direct consequences for whether patients ultimately receive treatment or not, and is source of inequalities in patient treatment. Therefore knowledge of how and why such practices are organised and undertaken may enable insight into the ways in which the scarce resource of donor gametes are allocated, and contribute to making this process more transparent.

It is hoped that the views and experiences of patients within this process will enable insight into the choices and decisions that are important to patients in selecting a donor, and enable understanding of why particular donor characteristics are important to patients. This is also the case for clinicians and policy-makers. Outside of the clinic, this information may also contribute to wider knowledge about professional and lay beliefs and understandings about genetic inheritance, race/ethnicity and non-traditional family formation. In light of the current lack of policy guidance on donor-recipient matching practices, it is hoped that this study will highlight the impact of legislation and policy rhetoric on clinician's practices and illuminate the meanings and processes which shape these practices in reality.

14/11/2012

8. Description of procedure for obtaining parental consent for research involving participants aged under 16 (or 18, if relevant). An opt-out only method will require a strong justification (see attached guidance).

N/A

9. Data security and destruction and data protection procedures.

All data will be stored securely and privately. Any manual paper files (such as consent forms, and personal contact details) will be stored in a locked and secure cupboard, and all electronic data will be stored in a password protected file on the researcher's password protected computer at a safe and secure location. The researcher will be the only person with access to these sources. Raw data, consisting of field notes, digital interview recordings and transcripts, and written documentation will be kept in a safe and secure place for at least ten years.

Personal addresses, emails, or telephone numbers will only be used for the purposes of contacting patients for a second interview or for providing feedback to patients about this study (with patients' written consent). If provided, these contact details will be separated from the data and stored in a locked and secure place to which only the researcher will have access. This personal information will be destroyed after their purpose has been fulfilled.

Section 4: Applicant's Statement

I am familiar with the RHUL and other appropriate subject-specific guidelines and have discussed them with the other researchers involved in the project.

I undertake to inform the Committee of any changes to the protocol or the staffing of this project

Applicant(s)

UG or PG Researcher(s) or research staff. If applicable:

Signed: Priya Darda Print Name: PRIYA DAVDA Date: 14/11/12

Signed: Print Name: Date:

Signed: Print Name: Date:

Signed: Print Name: Date:

Lead Researcher or Supervisor:

Signed: Print Name: Date:

Head of Department (or designate) statement of support (if project is to be forwarded to the College Ethics Committee)

The candidate provides a fullsome discussion of the ethical issues arising from the study. This is a careful consideration of the emotional risks connected to the research - issues of anonymity and the problems associated with researching in a clinic setting are also considered. I'm happy to support the study as it is outlined here.

J. Wallace 21/11/2012

Section 5: STATEMENT OF ETHICAL APPROVAL

Applicant:.....
Department:.....
Title of project:.....
Start Date:.....

Please complete the appropriate section below:

1. This project has been considered and has been approved by the Department of *CRIMINOLOGY* for *the duration of the study* months.

Signed: *[Signature]* Print Name: *SARAH MOORE*
Date: *21/11/2012*
(Chair, Departmental Ethics Committee)

2. This project has been considered by the Royal Holloway, University of London Research Ethics Committee and is now approved for months.

Signed: Print Name:

Date:
(Chair, RHUL Ethics Committee)

3. This project has been approved by Chair's action and is authorised for months.

Signed: Print Name:
Date:
(Chair, RHUL Ethics Committee)

Appendix 2: Clinician Information Sheet



Exploring the Practice of Donor-Recipient Matching in UK Fertility Clinics

Participant Information Sheet for Clinicians

You are invited to participate in a research study which focuses on practices of matching egg and sperm donors with recipients in UK fertility clinics. This Information Sheet will outline the research study, the nature of your involvement and who to contact should you have any further questions.

The Researcher

My name is Priya Davda, and I am a PhD student at Royal Holloway, University of London.

Purpose of study

The aim of this study is to describe how egg and sperm donors are selected and matched with recipients, and to explore the views and experiences of patients and clinicians within this process. Despite the practice of matching being a central consideration in the treatment of patients needing fertility treatment with donor eggs and sperm, little is known about the ways in which this practice is carried out, or about the views and experiences that inform it.

Why has my clinic been chosen for this study?

Your clinic has been chosen to participate in this study because it offers fertility treatment to patients in need of donor gametes, and consequently undertakes the practice of donor-recipient matching. This study will take place in 2 fertility clinics, your clinic and one other, and will be undertaken in a similar fashion in each.

Why have I been chosen to take part in this study?

You have been chosen to participate in this study because of your role in matching egg, sperm, and embryo donors and recipients, or in managing these practices.

What does participation in this study involve?

This study will involve a range of data collection methods, such as observation of matching-related activities within your clinic, and undertaking interviews with clinicians and patients.

For observations, the researcher will spend 2-3 days a week in your clinic, for around 6 months. This will include the researcher observing day to day clinician activities pertaining to matching, attending staff meetings and observing relevant patient-clinician consultations in order to understand how donor characteristics are selected.

Interviews will last for approximately 1 hour, and will be used to explore: your views and experiences of the matching process; some of the difficulties faced; the use and importance of social and physical characteristics; and how you think the processes associated with matching could be improved. With your permission, the interview will be digitally recorded and transcribed, otherwise hand-written notes will be made during the interview. Interviews will be undertaken at your convenience.

Is Participation Voluntary?

Yes, participation in this study is entirely voluntary. If, for any reason, you object to being observed and/or interviewed, the researcher will cease any observations pertaining to you and will refrain from interviewing you. The decision not to participate in this study can be taken at any point before, during and after data collection, without any further consequence. If you withdraw from this study, data collected from your participation up until that point will be erased. You will be asked to sign a written consent sheet by the researcher to show that you have understood the nature of this study and your role in it, and that you are happy to participate.

If you decide that you would not like to be included in this study, or have any concerns about the way this study is being carried out, please either contact the researcher or the clinic's Manager (see below for details).

What are the potential risks/benefits of taking part?

There are little anticipated risks to participants taking part in this study. It is hoped that the findings of this study will contribute to an understanding of how donor-recipient matching practices are undertaken in fertility clinics in the UK, and enable understanding of the views and experiences of those who deliver, receive and regulate this practice.

Will data collected from my participation be kept confidential?

Yes. Any notes taken from observations or conversations with members of staff will be kept strictly confidential, and any comments that you or your colleagues share will remain anonymous. Your name and any details which could potentially identify you will be removed or changed in the data collection, analysis and reporting of this study.

All of the data collected will be stored securely and privately; paper materials will be locked in a cupboard at a safe location, and electronic materials will be stored in a password protected file on a secure computer at a safe location.

What will happen to the results of this study?

The results of this study will be disseminated amongst participating clinics, academic and professional conferences, and in academic journals. All individual participants will also be given the opportunity to receive a summary of the findings of this study, and to discuss these further.

Funding of this study

This study is funded by the South West Academic Network, an alliance between St. Georges University, Royal Holloway University and Kingston University.

Ethical Approval

Consent to undertake this study has been granted by the clinic's Manager and the Ethics Committee at Royal Holloway, University of London. The researcher has also signed a form of non-disclosure at each clinic.

Contact for further information

For further information or if you have any concerns about the way this study is carried out, please contact either:

Researcher: Priya Davda, Dept. of Criminology and Sociology, Royal Holloway University, Egham Hill, Egham, Surrey, TW20 0EX. E-mail: p.davda@rhul.ac.uk, or Telephone: 01784 443156

Study Supervisor: Professor Jonathan Gabe. E-mail: g.gabe@rhul.ac.uk, or Telephone: 01784 276614

Clinical Manager: [Name and contact details of clinic's Manager]

Thank you for your time

Appendix 3: Recipient Information Sheet



Exploring the Practice of Donor-Recipient Matching in UK Fertility Clinics

Participant Information Sheet for Patients

You are invited to take part in a research study, which will explore how egg and sperm donors are matched with recipients in UK fertility clinics. This Information Sheet will outline the research study, the nature of your involvement and who to contact should you have any further questions.

The Researcher

My name is Priya Davda, and I am a PhD student at Royal Holloway, University of London.

Purpose of study

The aim of this study is to describe how egg and sperm donors are selected and matched with potential recipients, and to explore the views and experiences of patients and clinicians within this process. Despite the practice of matching being a central consideration for patients needing fertility treatment with donor eggs and sperm, little is known about the ways in which this practice is carried out, or about the views and experiences that inform it.

Why have I been invited to participate in this study?

You have been invited to take part in this study because you are in the beginning stages of your fertility treatment, and because you have a consultation booked at the clinic where you will discuss your choice of donor characteristics.

What does participation in this study involve?

Taking part in this study will involve allowing the researcher to observe your consultation with the clinic in which your preferences for a donor will be discussed. The researcher will not intervene in your consultation at any stage, and may make some handwritten notes.

After your consultation you will be invited to take part in an interview, lasting approximately one hour. This time will be used to discuss your views and experiences in relation to selecting a donor, which donor characteristics are important to you, and how you think the process of selecting a donor could be improved. With your permission, the interview will be digitally recorded and transcribed, otherwise hand-written notes will be made. You will be given the option of having an interview alone, or as a couple. If your clinician matches you with a potential donor within the 6 months that this study is being undertaken at your clinic, with your permission, you will also be invited for a second interview after you have decided whether to accept or decline this offer.

Is Participation Voluntary?

Yes, your participation in the study is entirely voluntary. The decision not to participate in this study can be taken at any point before, during and after data collection, without reason, and without affecting your treatment at the clinic in any way. This Information Sheet will be sent to you in advance of your consultation at the clinic. When you arrive at the clinic, you will be asked whether you are interested in taking part in this study. If you decide not to take part, you will not be contacted again.

If you decide to take part, the researcher will answer any questions that you have and request that you sign a written consent form to show that you understand the information provided to you and that you are happy to participate. If you withdraw from this study, data collected from your participation up until that point will be erased.

What are the potential risks/benefits of taking part?

There are little anticipated risks to taking part in this study. Given the sensitive nature of issues surrounding donor fertility treatment, it is recognised that infertility and undergoing fertility treatment can have significant emotional, psychological and physical consequences for those affected. If you find that you are upset or troubled by some of the issues arising from this study, contact details for some sources of support are provided at the bottom of this Information Sheet. If you have any concerns about this study or would like to refrain from participating, please contact either the researcher or the clinic's Manager (see below for contact details). It is hoped that the findings of this study will contribute to an understanding of how donor-recipient matching practices are undertaken in fertility clinics in the UK, and enable understanding of the views and experiences of those who deliver, receive and regulate this practice. The researcher will not access your personal records at any time.

Will data collected from my participation be kept confidential?

Yes. Any notes taken during this study will be kept strictly confidential, and any comments that you or your clinician make will remain confidential and anonymous. Your name and any details which could potentially identify you will be removed or changed in the collection, analysis and dissemination of this study.

All of the data collected will be stored securely and privately; paper materials will be stored in a locked cupboard at Royal Holloway University, and electronic materials will be stored in a password protected file in a safe location.

What will happen to the results of this study?

The results of this study will be disseminated amongst participating clinics, academic and professional conferences, and in academic journals. All individual participants will also be given the opportunity to receive a summary of the findings of this study, and to discuss these further.

Funding of this study

This study is funded by the South West Academic Network, an alliance between St. Georges University, Royal Holloway University and Kingston University.

Ethical Approval

Consent to undertake this study has been granted by the clinic's Manager and the Ethics Committee at Royal Holloway, University of London. The researcher has also signed a form of non-disclosure at each clinic.

Contact for further information

For further information or if you have any concerns about the way this study is carried out, please contact either:

Researcher: Priya Davda, Dept. of Criminology and Sociology, Royal Holloway University, Egham Hill, Egham, Surrey, TW20 0EX. E-mail: p.davda@rhul.ac.uk. Or Telephone: 01784 443156

Study Supervisor: Professor Jonathan Gabe. E-mail: g.gabe@rhul.ac.uk, or Telephone: 0 1784 276614

Clinical Manager: [Name and contact details of clinic's Manager]

Further Sources of Support

Infertility Network UK: website: www.infertilitynetwork.com or Telephone: 0800 008 7464

Fertility Friends: website: www.fertilityfriends.co.uk

Donor Conception Network: website: www.donor-conception-network.org or Telephone 0208 245 4369

Thank you for your time

Appendix 4: Clinician Consent Form



Study Title: **Exploring the Meanings and Practices of Donor-Recipient Matching in UK Fertility Clinics**

Participant Consent Form for Clinicians

Name of Researcher: Priya Davda

Contact details: p.davda@rhul.ac.uk or 07946 739894

Please mark boxes

I confirm that I have read and understand the information sheet for the above study, and that I have had the opportunity to consider the information, ask questions and had these answered satisfactorily

I understand that my participation is entirely voluntary, and that I am free to withdraw from this study at any time, without reason or repercussion

I agree to take part in this study by being observed by the researcher

I agree to take part in this study by being interviewed by the researcher

I agree to have my interview recorded and transcribed anonymously by the researcher

I understand that my identity and any information that I share will remain confidential and anonymous throughout the data collection, analysis and reporting of this study

If you would like to receive a summary of the research findings, please provide your contact details for feedback (your contact details will only be used for this purpose)

Contact Details: _____

_____	_____	_____
Name of Participant	Date	Signature of Participant
_____	_____	_____

Name of Researcher	Date	Signature of Researcher
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When completed, 1 consent form will be given to the participant, and 1 form will be stored securely by the researcher

Appendix 6: Topic Guide for Clinicians

Core Topics: Organisation of Clinic, Roles in Matching Process, Organisation of Matching Process, Aims of Matching, Ethnic Matching, Classification of Characteristics, View of Recipients and Recipient Choice, View of Matching Process, View of Donor Information,

[Ask as relevant to role]

Background/Role

- Can you tell me a bit about your role in the clinic? What do you do? Responsibilities? What don't you do? Role in the matching process
- How long have you been here? What did you do before?
- [demographic info- ethnicity, nationality, age, gender]

General

- What type of recipients are typical at the clinic? And less typical?
- What types of donors do you have in the clinic? Have you refused any potential donors?
- Why do you think donors donate?
- Why do you think recipients seek treatment with donor eggs?
- Are there any types of recipients you would not accept for treatment
- What is the role of counselling in the clinic?

Recipients Agency

- What do recipients want in their donor? What preferences can they state in the clinic?
- Are there are preferences that you would not allow? Why?
- What unusual requests have you come across? Have you refused any recipient requests?
- Do all recipients accept donors?
- What do you think shapes recipients preferences? Variability between them?

- Do recipients decline donors? Why do you think this is? What characteristics do recipients decline donors on the basis of?
- What do you think about recipients having more choice in the matching process? (e.g. select own donors have more information)
- What do recipients want to know about their donor? What type of donor information are you willing/unwilling to give?
- What do you think about the amount of information that recipients get about their donors? Do you think they should get more/less?
- What information do you record about donors and recipients?
- How is the process of classification undertaken? Who does it? Categories? Tools?
- What happens if there is a disparity in opinion?
- How do you classify ethnicity?
- How do you classify skin tone?

Matching Process

- How is the matching process organised in the clinic? Talk me through process step by step? Decision-making stages and processes?
- What is your role in the matching process?
- What is the purpose of matching?
- What criteria do you match by?
- What criteria do you prioritise when matching? Same for all recipients?
- Are there any welfare of the child concerns in matching?
- What is the role of ethnicity in matching?
- What are your views on ethnic matching? Is this something you try to do?
- What is ethnicity?
- Is there a relationship between Welfare of the Child considerations and ethnic matching?
- What are the barriers and constraints to matching?

- What is an ideal match?
- What is the role of hobbies and social characteristics in the matching process?
- Are there any types of donors/recipients that you find easier to match than others?
- Are there any types of donors/recipients that you find more difficult to match than others?
- Are there any types of matches that you would not make? What would be regarded as an unacceptable match?
- What characteristics are you willing to compromise on when matching?
- Is there any policy on matching ? Inside clinic? Regulation?
- How could the matching process be improved?
- What do you think of the American context of egg donation and matching? [briefly explain little regulation, free market, highly prized individual choice]
- What do you think about the UK system of matching? (donor allocation)

Appendix 7: Topic Guide for Recipients

Core Topics: background and trajectory towards egg donation, preferences for donor characteristics, donor information, view of matching process, view of clinic, view of donors offered, practices of declining and/or accepting donors

Background Information

- What led you to choosing egg donation in your fertility treatment? How do you feel about it?
- Have you had fertility treatment in the past? With donor eggs? Been to any other clinics?
- Why did you decide to have fertility treatment with donor eggs?
- When did you join this clinic? How long did you wait for a donor? Why this clinic?
- Why the UK?
- How was your overall experience of matching at this clinic?
- [other details: ethnicity, gender, age, educational background, occupation, existing children]

Donor Preferences

- What did you want in your donor?
- What were your preferences for donor characteristics, before you were matched?
- What preferences did you state in the clinic? Were there any others that you couldn't state in the clinic? [see reference list below]
- Why were these characteristics important to you?
- How was your experience of stating your preferences at the clinic?
- Are there any characteristics that you wouldn't accept in a donor? Why not?
- What would an ideal match be?
- Did the father's characteristics matter?

[Reference list for characteristics: ethnicity, hair colour, eye colour, height, weight, skin tone, occupation, education, hobbies, religion, attractiveness, personality, intelligence, health, fertility, donor type- altruistic, sharer]

View of Donors

- When comes to mind when you visualise/think of the donor? image?
- Are there any characteristics that you would like your child to have?
- Is it important that the donor matches your characteristics?
- Do you have any thoughts about the genetic inheritability of your donors' characteristics?
- Did the motivation of your donor matter?
- How do you feeling about the removal of donor anonymity?

Clinical Context and Matching Process

- What was your experience of having treatment at this clinic like?
- What did you think of the matching process at this clinic? Was it a good experience? Anything that could have been done better?
- How long did you wait to be matched with a donor? What was that period like?
- Would you have liked to have more control over the matching process? would you have liked to have more choice in selecting a donor? (i.e. choosing between multiple or choosing own), State more preferences? Have more information? How would you feel about choosing your own donor?
- How did you feeling about the nurses selecting your donor on your behalf?
- How could the matching process be improved?

Offered Donors

- What did you think about the donor that you had just accepted? What were you most pleased about? Unsure or concerned about?
- Why did you accept your donor?
- Did the donor you accept meet your preferences?
- How much information were you given about your donor? What did you think about this amount? Did you want more? Was it enough? Was there any other information you would have liked, or not liked?

- Do you think your expectation of choosing a donor have changed over time ... your experience of treatment?
- Had you previously declined any donors that you were matched with? How many? Why?

Wider Context

- Did the change in donor anonymity have any impact on your thoughts about choosing egg donation and choosing a donor?
- Have you told others about your use of egg donation? Who? What? Any persons not told? Don't want to know? Why?
- Do you intend to disclose to your child? Why?
- What do you think of the American context of egg donation and matching? [briefly explain little regulation, free market, highly prized individual choice]
- What do you think about the UK system of matching? (donor allocation)

Partners

- Same themes as above.
- How has your experience of the egg donation process been?
- Did you have any additional or other preferences for donor characteristics? Did you agree with your partner's preferences?

Appendix 8: Sample Recipient Coding Frame

Experience of (Infertility) and Egg Donation

- History
- Diagnosis
- Infertility as Surprise/Painful
- Infertility and Egg Donation as Stigmatised
- Impact of wider networks/media
- Decision to use anonymous egg donation
 - o Crazy to Necessity
 - o Anonymous over Known
- Concerns and Questions about Egg Donation
 - o Relationship to Child
 - o Resemblance with Child
 - o Family Legitimacy
 - o Role/Rights of Donor
 - o Counsellor not helpful
 - o Counsellor helpful
- Disclosure
 - o To others
 - o To child
- Gay Couples
 - o Expected non-reproduction
 - o Egg Donation as “luxury”
 - o Other concerns

Perception of Donor

- Substitute for Self
- ‘Tissue’ Donor
- Stranger
- Good Donors
- Bad Donors
- Type of Donor
 - o Egg Sharers
 - o Compensated Donors
- Concerns about Donor
 - o Motivation
 - o Exploitation
 - o Honesty
 - o Health

Resemblance

- Perception of Self

- Purpose of resemblance
 - To Pass
 - Bonding
- Consequences of no resemblance
 - Risk to Welfare of the Child
 - Risk to Family Legitimacy
 - Risk to Belonging to Wider Community

Preferences for Donor Characteristics

- Priorities
 - Health / Fertility
 - Clinic Screening of
 - Resemblance
 - To Self
 - To Partner
 - Race' / skin tone
 - Weight/height
 - Hair Colour
 - Eye Colour
 - Important
 - Not Important
 - Social characteristics
 - Ethnicity
 - Religion
 - Education
 - Attractiveness
- Gay Couples – no preference
- RACE: Inclusion and Exclusion: Difference and Sameness
 - White Recipients
 - No BME Donors
 - Unacceptable White Donors
 - Asian
 - Acceptable White Donors
 - White Donors Unacceptable
 - Unacceptable Asian Donors
 - Black African/Caribbean
 - Unacceptable White
 - Acceptable Asian
 - Unacceptable Asian
- Characteristics Unwilling to Accept/Declined
 - Dark Skin tone
 - Poor Health/Lifestyle
 - Red Hair
 - Overweight
 - Muslim
 - Poor/Criminal/Uneducated
 - Poor Health/Fertility

Conceptualisation of Race/ethnicity

- Physical features/Skin Tone
- Cultural connection
- Religion conflation
- Discrimination
- Desirability
- Indicator of kinship
- Risk to kinship

Declining Donors

- Circumstance
- 'Undesirable' Characteristics
- Donor Characteristic
 - o Lack of general resemblance
 - o Overweight
 - o Red Hair
 - o Dark Skin Tone
 - o Lesbian
 - o Education/Occupation
 - o Health/Fertility/Age
 - o Lack of Trust in Clinicians
- View of Declining Donors
 - o Immoral
 - o Natural
 - o Delays to Treatment

Reasons for Excluding and DECLINING

- o Risk to Welfare of the child
- o Risk to Kinship Resemblance
- o Risk to reproduction of Self

Strategies for Accepting Difference

- Contextual Constraints
 - o Shortage of Donors
 - Ethnicity
 - o Time
 - After pregnant
 - o Trust in Clinicians
 - o Clinic matching criteria
 - o Clinicians Guidance
- @ end of the day
- Dominance of Partners' Genes

- Displacing Role of Donor
- Alternative Generic Discourses
- Social Connections with Donor
- Disentangling Resemblance and Kinship
 - o Differences between immediate family
 - o Differences within wider family

Use of Genetic Discourses

- Geneticisation
- Nurture over Nature
 - o But ...
- Unilateral Inheritance
- Recessive Inheritance
- Uncertainty

View of Clinicians and Matching Process

- Stages in Process
 - o Happy
 - o Lack of Control
 - o Waiting time for Donor
- Relationship with Clinicians
 - o Trust
 - o Questioning
 - o Breakdowns in Trust
- View of Matches Offered
 - o Happy
 - o Unhappy
 - o Unhappy but Compromised
- View of Donor Information
 - o Amount of Info given
 - o Purpose of Information
 - o Accuracy of Information
 - o Wanted more
 - o Not want more
 - o Recipients' Partners' view

Appendix 9: HFEA Donor Information Form

Donor Information form



PLEASE WRITE CLEARLY IN
BLACK INK USING BLOCK CAPITALS

Centre:

Form D:

1. What this form is for

Is registering a new donor: Replaces all details previously registered:

This form replaces form D:

Form completion date:

Donor number: Previous donor number (if changed):

This donor was also registered as patient/partner number:

Date gametes produced for use:

Any donations at other centres? No Yes

If yes, last UK or overseas centre for donor (if known):

2. Donor contact details

Current first name(s):

Current surname:

First name(s) at birth (if different from current):

Surname at birth (if different from current):

Date of birth:

Gender:

Marital status: Single Married

Cohabit Divorced Widowed

Place of birth:

Country of birth:

NHS Number for UK resident (if known):

OR

Passport/ID Card Number:

Country of issue:

Donor address at date of form completion:

House name or number

Street name

Town

County

Postcode

Country

3. Personal details

Was the donor adopted? No Yes

Was the donor conceived by donation? No Yes

Ethnic group:

Donor's own ethnic group

Biological Mother's ethnic group (if known)

Biological Father's ethnic group (if known)

Please see form completion manual for current ethnicity codes

Please list any physical illness or disability, history of mental illness or learning difficulties. Please also list any known medical conditions within the donor's biological family.

The maximum number of families the donor consents to creating

Does the donor have their own biological children: No Yes

If yes, how many: Girls Boys

Donor's current height (m): Donor's current weight (kgs):

Eye colour: Blue Brown Green Grey Hazel

Other:

Natural hair colour: Black Brown dark Brown light
Blonde light Blonde dark Red

Skin colour: Light/Fair Medium Dark Freckles Olive

Please list any screening tests other than HFEA mandatory tests carried out for this donor.

4. Optional Additional Information

**This page is to be completed by the donor.
PLEASE WRITE CLEARLY IN BLACK INK USING BLOCK CAPITALS.**

In the spaces below please supply a description of your:-

Religion or belief systems:

Occupation:

Interests:

Skills:

Reasons for donating:

You may wish to provide in these sections a goodwill message and description of yourself. This information is not compulsory but it is recommended you complete these sections as the information you provide can help parents tell children about their origins and answer some questions a donor-conceived person may have.

Non-identifying information provided in the following sections can, upon request, be shared with patients requiring treatment with donor gametes/embryos, parents of children conceived using your donated gametes/embryos and children conceived using your donated gametes/embryos, once they reach the age of 16. The full content of this form can be made available to donor-conceived people when they reach the age of 18.

I understand that by completing these sections I have consented to the information therein being shared with patients, parents and donor-conceived people, as outlined above.

(Please tick to confirm)

You may wish to write a goodwill message for anyone born as a result of your donation.