

MOTHER COUNTRY:
REPRODUCTIVE TOURISM IN THE AGE OF GLOBALIZATION

by

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Abstract

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Mother Country is a multi-sited, qualitative study of the United States fertility industry. I analyze the industry in two dimensions: as a particularly American institution and nascent profession, and as a destination for “reproductive tourism.” The United States fertility industry, buttressed by lax federal regulation, free market principles, and high technology resources, is organized to benefit certain classes of American citizens and foreign nationals in their quest to have children. As such, the United States has become a prime destination for people seeking assisted fertility services such as commercial surrogacy, egg donation, and sex selection, which are unavailable, inaccessible, or illegal in many countries.

I employed a grounded theory and mixed-methods approach to my topic: I used participant observation and in-depth semi-structured interviews in three major metropolitan regions (New York City, Los Angeles, and San Francisco), to generate thick, empirical data about the fertility industry in these respective cities. I also employed ethnographic content analysis of medical and scientific journals, newspaper reports, and industry marketing materials, and comparative policy analysis on the state, federal, and international level to identify trends and patterns about the global state of the field.

I find that the United States produces ideal conditions for a fertility industry with a global reach. It boasts a robust network of fertility doctors, family law attorneys, and egg donation and surrogacy brokers, in addition to advanced technologies, high success rates, and lax federal regulation that enables clients to obtain services in locales with policies amenable to their needs and desires. Moreover, the profession itself has situated itself in such a way that enables it to secure its position as an autonomous body with gatekeeping functions, as professional organizations establish norms of self-regulation absent the teeth or enforcement of law.

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Introduction

When I walked into Deirdre's¹ family law office in a suburb of San Francisco, the first thing I noticed, aside from a life-sized statue of a Dalmatian, were four giant bulletin boards absolutely filled with photographs of babies. Although there were an overwhelming number of them, I was not shocked by the sight of so many babies. I'd been seeing them everywhere, ever since I started conducting research on the United States fertility industry. Practically every waiting room I'd spent time in—in New York City, in Los Angeles, in San Francisco—it was babies, babies, everywhere.

Deirdre was just one of twenty people I interviewed about their experiences helping international clients obtain assisted fertility services in this country. Over a lunch of mediocre Chinese food, Deirdre answered questions and told me stories about how some of those babies featured on her bulletin boards came to be. Thus I learned about a couple she worked with from Japan, where surrogacy is not legally recognized:

The woman didn't want anyone to know it was a surrogacy, so she got pictures of the surrogate, and every week added a new pillow. And said to people that she was coming to the United States for the last eight weeks of pregnancy because there was something wrong with the baby, and they could do surgery on the baby in the womb, so she was coming here, and she was going to stay here [in case she needed to be] hospitalized. And then she returned with the baby, and it all worked, but it was like, wow!

This case may have the element of sensation, but it also typifies many aspects of what traveling to the United States for assisted fertility services has to offer: circumvention of law, anonymity and privacy, and high-tech resources. Reproduction—including conception, pregnancy, parturition, and childrearing—is a deeply private matter involving deeply private choices. Yet procreative decision-making is not only a personal issue. Private choices about

¹ Not her real name.

family building are made in the context of national and global phenomena such as market forces, scientific innovation, state policies, and multilateral agreements.

Procreation has been commodified since at least the days of slavery with its reproduction of human bodies as property (D. E. Roberts 1997), but the explosion of assisted reproductive technologies (ART) since the 1970s has sped up and spread the commodification process. These technologies enable reproductive parts and processes to be collected from, transferred to, and performed by multiple entities in commodity chains of baby-making enterprises, in which bodies are pumped with pharmaceuticals, sperm and eggs are harvested, wombs are rented, and embryos are created and selected in the laboratory.

Reproduction has long been globalized, too, for example with the migration of women as domestic workers (Sassen 2002), but the commercialization and fragmentation of procreation produced by reproductive technologies enables the manufacture and handling of those reproductive parts and processes to be outsourced globally. No longer confined to the bedroom or to the body, procreation is a malleable and highly mobile process. The creation of one single child can involve numerous people, none of whom necessarily live in the same locality.

Procreation is not only susceptible to commodification and globalization, but it has also long been subject to governance. State actors intervene in shaping their citizens' procreative choices through policies and regulations. Foucault (2007), in his 1978 lecture introducing the concept of "governmentality," argues that the family is an instrument through which the state governs population; in *The History of Sexuality: Volume 1*, he introduces the related concept *biopower*, in which norming institutions such as the state, medicine, and education exert disciplinary control over bodies and regulation over populations (Foucault 1978). Eugenic sterilization in Nazi Germany and the United States, the total ban on abortion in Nicaragua,

China's one-child policy, and Romanian pronatalism are just some examples of interventions in the reproductive capacities of a country's citizens that have had serious demographic consequences. Public and medical policies regarding assisted fertility, I argue, are linked to this governmental and biopolitical authority. Further, as Federici (2004) reminds us, the disciplinary arm of the state is not a gender-neutral one, and the state's attempts to regulate population has historically occurred through control of the bodies of women (16).

These dynamics—the commodification, globalization, and regulation of assisted reproduction—are daily expressed and challenged within and through the United States fertility industry. *Mother Country* is a study of the United States fertility industry in two dimensions: as a particularly American institution and nascent profession, and as a destination for “reproductive tourism.” That is, the United States fertility industry, buttressed by lax federal regulation and free market principles, is organized to benefit certain classes of American citizens and foreign nationals in their quest to have children through medically assisted conception.

BACKGROUND

Reproductive tourism is a phenomenon in which people travel significant distances, often across national borders, in order to access such reproductive technologies and services as in vitro fertilization (IVF), egg donation, sex selection, surrogacy, and preimplantation genetic diagnosis (PGD). These services enable people with infertility issues, single people, and gay and lesbian couples to conceive and bear biologically related children with the assistance of medical technologies and third parties. Some of these services also enable intended parents to reduce the chances of having children with genetic conditions, or to select for certain traits such as sex. Technically, reproductive tourism can also refer more broadly to any kind of cross-border

reproduction or reproductive health care, including adoption, contraception, and abortion.

However, in its most popular usage by scholars and in the mainstream media, it typically refers to services involving medically assisted conception, and is often framed as a subset of medical tourism, or travel to obtain health care. International hubs of reproductive tourism have sprouted throughout the world enabling people to globetrot in search of affordable, legal, and efficient fertility services, sometimes in a relaxing vacation-like environment.

It is not clear when people first began engaging in reproductive tourism, but global fertility services have in the past decade become a fast-growing multibillion-dollar industry. India has been a large focal point of both media and scholarly attention (S. Banerjee and Basu 2009; Burke 2010; Carney 2010; Chen 2010; Hochschild 2009; Ramesh 2006), but dozens of other countries—including the United States—have also emerged as destinations (Blyth 2010; Nygren et al. 2010). Besides individual clinics and providers expanding their market from local clientele to people all over the world, medical tourism entrepreneurs have created specialized agencies and brokers expressly to help facilitate communication and services between intended parents and clinics, physicians, attorneys, egg donors, and surrogates across borders. As the global fertility market expands, and the mainstream media turns its eye on reproductive tourism, scholars in such diverse fields as bioethics, anthropology, sociology, and jurisprudence have also begun to study and analyze this phenomenon.

Like the term “medical tourism,” the phrase reproductive tourism has been adopted by the mainstream media without being adequately theorized. Definitions of “tourism” are contested within the field of tourism studies, and reproductive tourism, as such, aligns with some and diverges from others. John Urry (2002), for example, defines tourism as a leisure activity in which people journey for a short period of time to a place that is neither work nor home, and

“[consume] goods and services which are in some sense unnecessary” (1). Such a definition is not compatible with the reproductive tourist, who does not travel for expressly leisure purposes, and who consumes goods and services that, from his or her point of view, are in fact necessary for the reproduction of biological offspring.

In contrast to Urry, Chambers (2000) argues that people engage in tourism for a number of reasons besides leisure, and that the tourism industry itself does not distinguish much between travel for business or pleasure since all sorts of travelers rely on the same infrastructure and services such as hotels, transportation, and restaurants. His rather loose definition is that “tourism shall be constituted of any kind of travel activity that includes the self-conscious experience of another place” (E. Chambers 2000:xii). Furthermore, he writes that a hallmark of modern tourism is the proliferation of reasons for travel; a leisurely vacation is merely one of many rationalizations for riding in an airplane to a distant locale for a weeklong trip (E. Chambers 2000:15). These specific rationales for travel are indicated by the increasing number of “types” of tourism prevalent today such as “sex tourism,” “eco tourism,” and of course “reproductive tourism.”

There has also been some debate regarding the use of the term “reproductive tourism” among those studying and writing about this practice. Knoppers and LeBris (1991) coined the phrase “procreative tourism” two decades ago, and over time “procreative” has generally been replaced with “reproductive.” More recently, several authors have argued that it is derogatory to describe this phenomenon as a form of tourism, which they contend implies that it is fun, leisurely activity, or that the term makes light of the utter desperation that leads many to cross borders for assisted fertility services (Casper 2011; Inhorn and Patrizio 2009; Matorras 2005; Pennings 2005b; Smith-Cavros 2010). Other terms suggested include “reproductive exile”

(Matorras 2005), “Travel ART” (Smith-Cavros 2010), and “cross-border reproductive care,” (Ferraretti et al. 2010; Pennings 2005b). It is the latter term that seems to have been most widely adopted as an alternative.

Despite the concerns, “reproductive tourism” continues to be the dominant phrase used in both scholarly research and journalism, and it continues to be linguistically and analytically linked to medical tourism (Sengupta 2011). As indicated by Chambers (2000), referring to a practice as tourism does not necessarily imply leisure or value judgment. Further, I would argue that by using the phrase “reproductive tourism,” one is cognizant of the power relations embedded in the practice, as intended parents use their economic capital while they are traveling not only to purchase the reproductive labor of others, but also to consume non-medical goods and services in foreign lands such as transportation, accommodations, food, entertainment, and souvenirs. For the purposes of this dissertation, tourism shall be understood as involving both a spatial and temporal element: it is a temporary interruption of one’s daily life to travel to a destination for a bounded set of time, and involves the consumption of goods and services in the course of those travels. As this definition implies, the goal of tourism may be for non-leisure purposes, including reproduction, and it does not intend to cast negative judgment on those who partake in this activity.

Reproductive tourism is a growing, global market. In future chapters I provide data from interviews I conducted with United States fertility industry professionals about their experiences working with international clientele. Although there are no comprehensive numbers as to how prevalent reproductive tourism is today,² every provider I spoke with indicated to me that they

² The International Committee Monitoring Assisted Reproductive Technologies (ICMART) recently attempted to collect data from 49 countries about the prevalence of cross-border fertility care. Their data indicates an estimated 5000 to 7000 treatment cycles between 23 responding countries, but the authors ultimately conclude that non-standardized data collection makes quantification of this practice at present unreliable (Nygren et al. 2010).

did not foresee reproductive tourism to the United States—or to other destinations they were familiar with—stemming at any time soon. Besides my interview data, websites of some international fertility clinics hint at this growing market. The Pacific Fertility Center in California, for example, has web pages in both English and Japanese, and advertises that they serve patients from “countries all around the world such as France, Germany, Yugoslavia, England, Vietnam, China, Philippines, and Japan” (Pacific Fertility Center 2011). Connections between reproductive tourism and traditional notions of tourism are made obvious at this clinic’s website by hyperlinks to information about San Francisco and local hotel accommodations.

This connection is made even more clearly by the Barbados Fertility Centre, which explicitly markets its services as a holiday getaway. The website boasts photographs of white sand, clear blue sea, and Caucasian couples in bathing suits, with text that reads: “In between your appointments, you have constant access to our team of experts by cellular phone but with the freedom of being on holiday. You can enjoy the soothing sound of the lapping Caribbean Sea, go for a long romantic walk along the white sandy beaches and then enjoy the tantalizing tastes of the Caribbean’s cuisine” (Barbados Fertility Centre n.d.).

In Spain, the website of the *Centro de Fertilización in Vitro de Asturias* (CEFIVA) is available in Spanish, English, German, French, and Italian. Although it does not boast pictures of sandy beaches and tanned bodies, this clinic uses the “small, peaceful city” in which the clinic is located as a selling point (CEFIVA n.d.). One should not overemphasize the conflation of reproductive tourism with leisure activities, however. This clinic also bluntly states, “The present Law governing Assisted Reproduction in Spain allows treatments to be carried out here which are restricted in other countries” (ibid).

Although reproductive tourism may be combined with vacation-like experiences, the focus of the trip is to access fertility services, and is thus a very specific type of tourism. People may engage in reproductive tourism in order to access cheaper, more efficient, or a wider range of services, or even to access those services in a relaxing environment, but, as the Spanish clinic's website attests, it is also practiced by those who aim to bypass regulations and laws in their home countries. As I elaborate in Chapter 2, there are several "logics" operating to drive reproductive tourism from and to various countries.

Consumers of reproductive technologies, like any citizens, are subject to their country's rules and regulations. Following Foucault (1978), government asserts its power over life and death; it affirms and organizes its powers over the social and individual body through discipline of sexuality and regulation of population. One can look to literature regarding population control, abortion, and birth control policies for examples of this governmental function (Bachrach and Bergman 1973; Bandarage 1997; Dixon-Mueller 1993; Petchesky 1990), or, as is argued here, one can also look to policies regarding reproductive technologies. All of these rules and regulations are framed by the interests of the state in managing its demographic needs and reinforcing the ethical, cultural, religious, economic, and political norms and values that are deemed central.

LITERATURE REVIEW

Although it has been two decades since reproductive tourism was first identified as a noteworthy phenomenon (Knoppers and LeBris 1991), there have not been many large-scale studies on this topic, and the precise numbers of people involved in this practice remain elusive. Newspaper, magazine, and television media have tended to sensationalize the subject, with

stories about celebrities or exposes of so-called baby farms in India. If anything, the media's focus on surrogacy in India, while it may be warranted, has also detracted from research conducted elsewhere. Less attention has been paid to other forms of reproductive tourism such as egg donation and sex selection, as well as to locations in North America, Eastern and Southern Europe, and the Caribbean, where reproductive tourism is also thriving.

Scholars currently studying reproductive tourism approach it from many disciplinary and methodological perspectives, including ethics (A. Banerjee 2010; Gamble 2009; Parks 2010; Pennings 2002, 2005a; Pennings et al. 2008), jurisprudence and policy analysis (Blyth and Farrand 2005; Deech 2003; Goodwin 2010; Langdrige and Blyth 2001; Merlet 2009; Spar 2005; Storrow 2005; Storrow 2010), and ethnography (Inhorn 2003; Bergmann 2011). This continues to be a rich, emergent topic for scholars of globalization, raising very pertinent questions about political economy, international law, travel and tourism, reproductive autonomy, and the murkiness of geographic and political borders.

There is considerable debate in both the mainstream and scholarly literature regarding the ethics of reproductive tourism. Concerns have been raised that reproductive tourism promotes the exploitation of egg donors and surrogates, undermines the laws and policies (and thus sovereignty) of nation-states, and reinforces existing global inequalities. Social scientists, bioethicists, and journalists have raised concerns about the living and working conditions of the egg donors and surrogates who provide services to an international clientele. Waldby (2008), for example, points to the possible link between egg donation and the global sex trade involving Eastern European women. Hochschild (2009), among others, has reported on the living conditions of women acting as gestational surrogates in India, where it is common for surrogates

to reside in dormitories throughout their pregnancies, separated from their own families (Carney 2010; Chen 2010; Gentleman 2008).

The increased global demand for egg donors and surrogates, some argue, drives clinics and programs to aggressively recruit women to perform reproductive labor that is not risk-free. The hormones that donors receive prior to the surgical removal of eggs from their body have the potential to hyperstimulate their ovaries, which can be a life-threatening condition. Pregnancy and childbirth also pose serious risks to surrogates—particularly in cases of twins and other multiples—and medical care varies in different nations (Parks 2010). One may argue that paying women, particular those who are poor or who lack education, to undergo these risky procedures for another family’s benefit is coercive (Donchin 2010). Furthermore, there are echoes of colonialism when relatively affluent people from high-income Northern nations rely upon the bodies of poorer women in the global South to fulfill their procreative desires (Donchin 2010; Parks 2010).

On the other hand, supporters of this practice argue that in places where there is a lack of employment opportunities for women, selling eggs or working as a surrogate can be a valuable source of money for the women and their families. Andrews (1999), writing about surrogacy in general (rather than international surrogacy) has argued in favor of paying women for their reproductive services, seeing it as just compensation, and an acknowledgement that reproductive labor is valuable work. Relying on a gift economy, wherein “altruistic” egg donors and surrogates get paid only a nominal fee, if at all, does not necessarily remove coercion or exploitation from the equation. Arguments in favor of egg donation and surrogacy are also made on the basis of self-determination, individual liberty, and bodily autonomy (Munyon 2003). That is, a woman’s body is her own, and it is within her right to determine what she does with it, even

if that includes selling her eggs or carrying and giving birth to a baby for money. Preventing women from participating as egg donors or surrogates is seen as a paternalistic act that denies their agency. Similar debates exist around the global sex trade (Desyllas 2007) and the market for human organs (Scheper-Hughes and Wacquant 2002).

Another aspect of reproductive tourism that has been cause for debate among ethicists and jurists is the right of intended parents to travel to other nations if they disagree with or are being discriminated against by the laws in their own countries of citizenship (Blyth and Farrand 2005). The lack of any international standards regarding assisted fertility services means that there are immense global disparities in the types of services and technologies that individuals may access. Furthermore, there may be disagreement *within* a nation regarding what types of services are culturally, ethically, or legally normative, or about what types of people should be able to access them. Policymakers set guidelines and laws to regulate the types of services and technologies that are available to the nation's citizens, yet those very guidelines and laws may drive individuals to seek ways around them, such as black markets or trafficking.

Pennings (2005a) argues that reproductive tourism can act as a “safety valve”—international policies will continue to differ and be distinct, yet intended parents living in more restrictive nations will be able to have their reproductive needs met (127). Counter arguments are that reproductive tourism renders those very policies meaningless if citizens are allowed to subvert them, and that it reinforces structural inequalities by enabling a privileged group of citizens to pick and choose which policies apply to them (L. J. Martin 2009). Some regions and countries are striking back against those who cross borders to subvert local laws by imposing criminal and financial penalties. New South Wales in Australia, which already bans commercial

surrogacy in its own borders, has recently made it a crime to go abroad to obtain and pay surrogates (Noone 2010).

Theoretical Frameworks

Beyond the specifics of reproductive tourism, this research engages with several theoretical and disciplinary frameworks, namely globalization studies, public policy, and medical sociology. At the core of this study is the question of how macro structures and forces such as global politics, the state, the market, and medicine determine or at least influence and interact with the micro processes of procreation and family-building. Each of these sub-disciplines help to individually frame this project, but the specific case of the United States as a destination for reproductive tourism requires an analysis of their combined effect.

It has become a truism to state that we are living in an age of globalization, yet scholars and activists have not come to a consensus as to what exactly constitutes globalization, or what distinguishes globalization in the twenty-first century from previous eras of internationalization and transnationalism. As Held et al. (1999) write, “Indeed, globalization is in danger of becoming, if it has not already become, the cliché of our times: the big idea which encompasses everything from global financial markets to the Internet but which delivers little substantive insight into the contemporary human condition” (1). Disagreement reigns as to the extent to which globalization has occurred, whether political, economic, or cultural transformations are most significant, and how those transformations should be regarded (Appadurai 2000).

This project takes a moderate stance on globalization that is neither gleefully optimistic nor catastrophic, but understands it as a transformative force that may produce beneficial and disadvantageous effects simultaneously. Globalization offers new opportunities and mobility at

the same time it reproduces structural inequalities. This is apparent in the effects of globalization and global capitalism on gender relations and the status of women (Acker 2004; Eisenstein 2005). Studies on the transnationalization of reproduction, for example, reveal new patterns of female migration, kinship structures, labor and childrearing that tend to empower those already privileged by gender, race-ethnic, class, nationality and/or immigration status at the expense and exploitation of others (Ehrenreich and Hochschild 2002; Ginsburg and Rapp 1995).

When theorists write and speak of globalization, the image that often forms is that of a smaller, interconnected, interdependent world in which people, goods, services, capital, information, and labor flow rapidly across national borders. Those emphasizing the economic impacts of globalization stress the rise of transnational production, finance, trade, and labor catalyzed by developments in technology, communications, and transportation, as well as multilateral trade agreements and international finance institutions (Economist 2006; Kay 2005; Stiglitz 2002). Others argue that globalization is having a deep anthropological effect on local cultures—if not a “leveling” then perhaps a convergence (Kearney 1995; Kymlicka 2004). Debates about globalization in the political realm involves the extent to which the role of the state has decreased in the face of free markets, treaties, regional confederations, intergovernmental organizations (IGOs), and non-governmental organizations (NGOs) and information networks (Ingram, Robinson, and Busch 2005; Stone 2001, 2002).

In examining the extent to which assisted reproduction has become globalized, the emphasis here is on political impacts. This dissertation examines how a global marketplace for assisted fertility services mediates tensions between state control and individual desire, in light of the global variation in policies regarding reproductive technologies. It is here where the interaction between globalization and policy studies emerges. Political theorists such as Skocpol

(1993), Esping-Andersen (1999), Abramovitz (1996), and Dickinson and Russell (1986) have incorporated the family into their analyses of the welfare state (or what Esping-Andersen terms the welfare *regime*), underscoring the need to examine the role of the state in procreative decision-making.

The figure of the state as disciplinarian (or perhaps as patriarch) is apparent in rights-based discussions concerning reproductive autonomy and bodily integrity. Abortion and birth control are two of the more well-known and researched topics in this area (Cornell 1995; Petchesky 1990; D. E. Roberts 1997), but it can also be applied to policies regarding reproductive technologies (Knowles and Kaebnik 2007; Markens 2007; McNeil 1990; Unnithan-Kumar 2004). Assisted reproductive technologies are rife with concerns for contemporary theorists of reproduction and the family, who have noted how these technologies may transform our conceptions of kinship and motherhood (Franklin 1995; Haimes 1990; Rothman 2000; Strathern 1995).

Besides the link with public policy, assisted reproductive technologies can be framed through the lenses of the sociology of medicine. Most obviously, the use of assistive technologies for procreative purposes raises questions about the ways in which infertility has been medicalized—that is, socially constructed as an illness defined by medical professionals to be treated medically (Conrad 1992). This is not to deny any biological basis of infertility, but to suggest that it is also largely a social problem, with social consequences, and often a social etiology (e.g. resulting from delayed childbirth, environmental toxins, or sexually transmitted infections). The use of assisted reproductive technologies may not even necessarily be part of any infertility treatment, but may be used for purely social reasons to help presumably fertile single women, lesbian couples, and gay men to have biological children. Diagnostic technologies

do not necessarily “treat” infertility either, but may be used to screen for or against particular genetic traits or “defects.”

Assisted reproductive technologies are bound in medical practice and are thus subject to bioethical concerns such as their implication for kinship norms, the commercialization of procreation, and the specter of genetic engineering and manipulation. Third party reproduction such as surrogacy and sperm, egg, and embryo donation raise questions about parental rights, genetic versus social parentage, and children’s rights to information about their genetic parents (Cussins 1998). The large sums paid to egg donors and surrogate mothers for medically risky procedures have been viewed as quite a large economic incentive that may be coercive, especially for poor young women (Steinbock 2004; Waldby 2008). Third party reproduction that involves the donation of genetic material raises questions about “designer babies,” wherein clinics attempt to find sperm and egg donors who fit particular criteria, such as race/ethnicity, hair and eye color, height, education, IQ, and talents (Daniels and Golden 2004; Moore 2007; Schmidt and Moore 1998).

Finally, diagnostic tools such as amniocentesis, chorionic villus sampling (CVS) and preimplantation genetic diagnosis (PGD) are fraught with ethical questions (Duster 2003; Rothman 2001; Rothschild 2005). Screening for genetic disorders demands some sort of response when disorders are identified. Does selective termination after amniocentesis, or the discarding of embryos after PGD lead us down a slippery slope towards eugenics and the elimination of people with disabilities? Should diagnostic tools be used to select for or against certain genetic traits such as deafness, Alzheimer’s disease, or breast cancer—and perhaps one day such traits as height, intelligence, or sexual orientation? Will those who can afford to use these technologies eventually produce a class of the genetic elite? Additionally, both

preimplantation genetic diagnosis and prenatal testing paired with selective abortion can be used for sex selection purposes, reinforcing and exacerbating gender inequalities with potentially catastrophic demographic consequences.

The large body of literature critical of reproductive technologies speaks of the complexities inherent in today's reproductive medicine. Sociologists, anthropologists, and other social theorists have noted how these technologies may reify economic, racial, and sexual hierarchies (Davis 1993; D. E. Roberts 2009; Schmidt and Moore 1998), further medicalize childbirth and reproduction (Rothman 2000; Wajcman 1994), be put to eugenic ends (Duster 2003; Nelkin and Lindee 1995; Rothman 2001; Rothschild 2005), and provide an embodied terrain on which political and cultural struggles are enacted (Ginsburg and Rapp 1991, 1995).

METHODS

I use a *grounded theory* approach, in which theorizing “is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon” (Strauss and Corbin 1990:23). I employed mixed qualitative methods, including participant observation, in-depth interviews, ethnographic content analysis, and comparative policy analysis. This involved multi-sited research in three metropolitan regions: New York City, Los Angeles, and the San Francisco Bay Area.

Participant Observation

Over the course of several years, I conducted unobtrusive participant observation at public events in New York City and the San Francisco Bay Area sponsored by fertility clinics,

programs and a non-profit advocacy group. These were publicized as educational events in newspapers, magazines, radio, direct emails, and organization websites. The events fell in three categories: “Open House” seminars, special topic seminars, and conferences. At Open House seminars (n = 5), fertility clinic staff members (usually physicians and other medical staff) presented educational information about infertility and infertility treatments, informed potential clients about their services, and often gave tours of the facilities. The special topic seminars (n = 3) were narrower in scope than the Open Houses, featuring formal presentations (also by physicians and other professionals) and moderated discussion about such topics as egg freezing, fertility preservation, and infertility prevention. Two of these seminars occurred onsite at clinics, but the third, as described below, took place at a nail salon. Both the Open House and special topic seminars typically lasted 1.5 to 2 hours, whereas the conferences (n = 2) were daylong events. The latter, both organized by the same non-profit organization but co-sponsored by fertility clinics, pharmaceutical organizations, and other corporate and non-profit entities, took place at conference centers and consisted of series of panels and workshops led by physicians, attorneys, and social workers on a variety of topics.

As a participant observer, I registered for and attended the events as a member of the public interested in learning more about the organizations and topics being presented. All of the events were free, except for the conferences sponsored by the non-profit organization, at which I volunteered in exchange for admission. I took brief notes during the seminars, and typed up longer field notes of my observations afterwards. Because I wanted my presence to be as unobtrusive as possible, for the most part I did not disclose my role as a researcher. For this reason, I have chosen to keep the names of all organizations and seminar presenters that I observed anonymous.

My role as participant observer was twofold. As a participant, my goal was to experience the seminars in the same way as the strangers sitting beside me: Was it a warm, welcoming environment? Did the sessions start on time? Were our questions answered thoughtfully? As an observer, however, my experiences were one step removed, as I aimed to take note of how the seminar organizers attempted to appeal to the participants. This entailed taking detailed notes about what kinds of information and materials were distributed to participants (e.g. pens, key chains, brochures, press clippings, egg- or sperm-shaped toys), what the space physically looked and felt like, the content of the presentations, and how presenters engaged with their audience. Although my observations focused on the speakers, I made notes about the composition of the audience in terms of age, race, and gender distribution, and whether people were attending by themselves or with presumed friends and/or partners. Participation at most events seemed to be evenly split between whites and people of color, including Asian, Latino/a, and Black individuals. Two of the special topic seminars were billed as “women only” events, but the other events had a mix of solitary women, heterosexual couples, and friend pairs. A wide range of ages were represented, with most participants appearing to be in their thirties. I did not record any identifying information about participants or their infertility status if they disclosed it.

In addition to participation at these public events, I also wrote extensive field notes and cover sheets after each interview, describing the physical environment of the offices and waiting rooms of each site, providers’ appearances, and any presenting questions, concerns, or things to follow-up on. I did not record any identifying information about any patients I encountered in these visits.

In-depth interviews

A central part of this research involved in-depth semi-structured interviews with people employed in the fertility industry in three regions. In order to understand the United States as a destination for reproductive tourism, I spoke with people whose jobs entail, in part, facilitating fertility services for an international clientele. My goal was to investigate how members of the fertility industry subjectively understand their role in the commodification and transnationalization of reproduction.

Sampling and Recruitment

I sampled and recruited providers in three major metropolitan regions: New York City, Los Angeles, and the San Francisco Bay Area. These regions are three of the most popular destinations for reproductive tourism within the United States. Selection and recruitment of subjects was made through the use of public records (including websites), participant observation at public events, and a minor bit of snowball sampling.

I found providers to contact to inquire about interviews via several sources, including the SART (Society for Assisted Reproductive Technology) online national database of clinics and fertility doctors, ASRM's (American Society for Reproductive Medicine) published list of approved egg donor agencies, and print and online directories of fertility professionals from the non-profit advocacy groups RESOLVE and the American Fertility Association (AFA). I also conducted Internet searches via Google, using such keywords as "New York egg donor," "California surrogacy," and "sex selection fertility clinic." Additionally, some providers I contacted were people I had met while conducting participant observation at public events. Although I had also hoped to use snowball sampling, when I asked providers if they could suggest other people for me to interview, the names they provided were often of people I had

already contacted. Snowball sampling only yielded one additional provider to interview. I contacted a total of 126 providers via email, which ultimately yielded 20 interviews, a response rate of almost 16%.

Table I.1 Recruitment

City	Number of providers contacted	Number of interviews scheduled	Response rate
New York City	50	6	12%
Los Angeles	38	8	21%
San Francisco Bay	38	6	15.7%
Total	126	20	15.8%

I aimed to interview a broad spectrum of providers. Of those I interviewed, occupations fell in several general categories, but physicians and “brokers” were the most represented. By “broker,” I am referring to those providers who work at egg donor or surrogacy agencies, or whose jobs involve recruiting or coordinating the egg donor or surrogacy programs at large clinics. I also interviewed two attorneys, a licensed clinical social worker, and an administrator (director of operations). Half of the providers I interviewed were executives (owners or managing partners) of their organizations.

Table I.2 Providers interviewed

Name ³	City	Interview Date	Occupation ⁴	Type of Program	Executive?
Dr. G	NYC	6/11/09	Physician	Clinic	X
Dr. B	NYC	6/12/09	Physician	Clinic	X
Dr. U	NYC	6/16/09	Physician	Clinic	X
Dr. M	NYC	6/30/09	Physician	Clinic	
Liz	NYC	7/9/09	Broker	Clinic (egg donation program)	
Jen	NYC	7/9/09	Genetic Counselor	Clinic	
Robin	LA	7/27/09	Broker	Egg Donor Agency	X
Michael	LA	7/27/09	Attorney	Law Firm	
Linda	LA	7/28/09	Administrator	Clinic	

³ Although some providers consented to using their real names, several requested a pseudonym. In order to be consistent, I have changed the names of all people I spoke with.

⁴ These “occupations” are not necessarily the providers’ official titles, but I have placed them within these general categories.

Anne	LA	7/28/09	Broker	Surrogacy Agency	
Liam	LA	7/28/09	Broker	Donor and Surrogacy Agency	X
Rebekah	LA	7/29/09	Broker	Donor and Surrogacy Agency	X
Shelby	LA	7/29/09	Broker	Donor and Surrogacy Agency	X
Dr. S	LA	7/29/09	Physician	Clinic	X
Megan	LA	7/30/09	Broker	Egg Donor Agency	
Dr. O	SF	8/5/09	Physician	Clinic	
Deirdre	SF	8/6/09	Attorney	Law Firm	X
Tammy	SF	8/12/09	Social Worker	Surrogacy Agency	
Dr. C	SF	8/13/09	Physician	Clinic	
Dr. H	SF	8/13/09	Physician	Clinic	X

Structure and Analysis of Interviews

Interviews took place in New York City, Los Angeles, and the San Francisco Bay Area over a period of three months in 2009. All interviews were conducted in person to enable greater rapport between myself and the providers I interviewed than would a phone interview. I also wanted to approximate as closely as possible the experience a client may have in meeting with providers face to face at their place of business. For this reason, all interviews, with two exceptions, were conducted onsite. One exception was the interview I conducted with Shelby and Rebekah, co-owners of an egg donor and surrogacy agency whom I had met at a fertility conference in New York City several months earlier. Because they do not have an office but instead both work out of their homes, we met at a coffee shop in a Los Angeles suburb. This was also the only interview in which I interviewed two providers at once. The other exception was Deirdre—although I met her at her office, and was able to observe the giant bulletin boards filled to the brim with photographs of babies—the interview took place over lunch at a Chinese restaurant.

Interviews were in-depth, semi-structured, and took approximately one to one and a half hours each. I created an interview protocol with open-ended questions to guide the conversation,

but I also allowed space for tangents and other questions to emerge organically. The approximate arc of the interview protocol is as follows:

1. Warm-up questions about career and organization
2. The state of the fertility industry
3. The organization of reproductive medicine
4. Demographics of clients
5. Interactions with clients
6. Reproductive tourism—process, challenges
7. How policy affects their practice
8. Perspectives on regulation

More specifically, some sample questions were:

Do you have any concerns about the state of the field of reproductive medicine either nationally or globally?

What do you think are the factors that go into your clients' decisions to work with your particular organization?

Can you tell me how exactly the process [of reproductive tourism] works—that is, how is the process different for your international clients than from your local clients?

Can you describe for me how, if at all, public policies and regulations affect your practice?

Given the recent debates about health care in the United States, do you foresee any changes in the regulation of reproductive medicine?

With one exception (Dr. U), providers consented to having their conversations digitally recorded.

For Dr. U's interview, I took notes by hand.

In the Fall of 2009, I transcribed all interviews, and then coded them using the qualitative analysis software Atlas.ti. Using grounded theory techniques (Charmaz and Mitchell 2001; Strauss and Corbin 1990), I created codes that emerged inductively from the data. According to Charmaz and Mitchell (2001), “Grounded theory codes arise *from* analyzing data, rather than from applying concepts from earlier works *to* data. When coding, researchers take an active stance toward their data. . . . They must ask questions of these data” (165). While I may have had

some preliminary ideas about themes prior to conducting the interviews, it is the data that I collected that pushed the subsequent analysis. Some examples of emergent themes and categories that I coded for included: “Challenges of Reproductive Tourism,” “Ethics,” “How Patients Choose,” “Liberalism,” “Market Driven,” and “Why USA.” Whereas “Ethics” is a generic category I coded for when conversation veered to a discussion concerning ethical matters or professional norms, the code for “Market Driven” emerged when I noticed a *pattern* in which providers described, challenged, or supported the idea that aspects of their work involve commercial transactions.

Ethnographic Content Analysis

For Chapter 6, I conducted an ethnographic content analysis of the new reproductive technology oocyte cryopreservation, colloquially known as egg freezing. I reviewed scientific (including medical and bioethics) journal articles, newspaper reports, and marketing materials. For science articles, I searched academic databases with the keyword “oocyte cryopreservation,” limiting the results to human populations. I searched LexisNexis using the lay term “egg freezing” to find newspaper articles. To further limit this sample, I focused on United States and British newspapers. I collected marketing materials including brochures, newsletters, direct emails, and websites from fertility clinics and non-profit organizations in the course of participant observation and Internet research.

I employed grounded theory methods and ethnographic content analysis to review these texts, extrapolating themes inductively from the data (Altheide 1987; Strauss and Corbin 1990). Once the theme of appropriate candidates for egg freezing emerged from an initial scan of the materials, I then selected those texts that addressed this theme. I coded to identify patterns in

how candidates for this technology are framed when egg freezing is discussed as a scientific discourse, as a topic of general human interest, and as a direct-to-consumer service.

Comparative Policy Analysis

I analyze a number of policies regarding assisted reproductive technologies to identify how regulation impinges on regionally based practice. Because of the comparative nature of this dissertation, I did an in-depth analysis of policies within the United States (on several levels, discussed below), and contrast them with policies of several other nations, including Australia, Germany, Israel, and the United Kingdom. The decentralized and federalist nature of United States government required examination beyond federal policy, and I relied upon data from the National Conference of State Legislatures (NCSL) to identify trends in policies on the subnational level. Since my research focuses on New York State and California, I paid especial attention to these states' policies. Finally, given the laissez-faire orientation of the United States towards assisted fertility (see Chapters 1 and 3), much of the practice of the fertility industry is guided not by legislation or government directives, but by norms and guidelines of professional organizations (Chapter 2). Thus included in the analysis were guidelines disseminated by the American Society for Reproductive Medicine (ASRM) and the Society for Assisted Reproductive Technology (SART).

Table I.3 Levels of policy analysis

Level of policy
International policy
United States federal policy
United States state-level policy (NYS and California)
Professional guidelines

CHAPTER OVERVIEW: From the Global to the Local

Chapters are organized from a macro to a micro perspective—in content, scope, and method—starting with a global and theoretical overview and ending with an empirical study of a specific reproductive technology. In Chapter 1, “Reproductive Tourism: A Global Perspective,” I use reproductive tourism as a case study of globalization, providing a theoretical and international backdrop for the rest of the dissertation.

Chapter 2, “The Logic of Reproductive Tourism: The United States as Destination,” zeroes in on this country as a receiving country for an international clientele desiring assisted fertility services. Based on my interviews with American providers, I theorize three “logics” that ultimately drive this practice.

In Chapter 3, “The ‘American’ Character of the United States Fertility Industry,” I formulate a “collective portrait” as described to me by providers. I analyze the “unique” or “exceptional” qualities of the United States fertility industry, particularly as it pertains to regulation (or lack thereof).

Chapter 4, “‘You Don’t Go to Jail if you Didn’t Follow Guidelines’”: Ethics, Professional Autonomy and the United States Fertility Industry,” furthers discussion of this field in terms of professional ethics. Whereas the prior chapter characterizes the laws governing the industry, this chapter analyzes the “Americanness” of the industry in terms of its practice.

Chapter 5, “The Genetic Imperative: Compulsory Motherhood Meets the New Eugenics” deals with another “logic”—this one not of reproductive tourism, but of assisted fertility itself. That is, I argue that genetic ideologies are part of what drives people to go to such great lengths (including spending tens if not hundreds of thousands of dollars, dealing with legal hassles, and

traveling halfway across the globe) to have biological children through medical assistance. I use egg donation as one example of this practice.

Finally, in Chapter 6, “Anticipating Infertility: Egg Freezing, Genetic Preservation, and Risk,” I continue to analyze the genetic imperative, this time focusing on one specific new reproductive technology: egg freezing. Although this chapter does not deal explicitly with cross-border travel, it has wider implications for reproductive tourism. That is, if egg freezing, which involves women harvesting and storing their own ova for future use, becomes more effective, it could potentially decrease the demand for commercial egg donation, and thus obviate one of the primary drivers of reproductive tourism.

Chapter One

Reproductive Tourism: A Global Perspective

In the age of globalization, one might question whether reproductive tourism undermines the governmental power of the state—at least for those privileged enough to subvert its mandates. When national and local policies forbid certain procedures (such as sex selection) or prohibit access by particular groups of people (such as unmarried women, lesbians and gay men, or women of non-traditional childbearing age), a fortunate few are able to travel to other jurisdictions to purchase those forbidden procedures or products. Thus citizens are still subject to governmentality as it applies to technologically-mediated procreation, but it is in the process of reproductive tourism that some citizens are transformed into global consumers, able to buy their way out of inconvenient or onerous policies.

Aihwa Ong (1999) cautions that such examples of “flexible citizenship” do not mean that the nation or even national borders are becoming irrelevant. From the consumer’s perspective, one can see reproductive tourism as a response to governmentality. And, according to Ong, states in turn continually respond and adjust to the vagaries of global capitalism and global markets. Given the range of policies regarding reproductive technologies throughout the world, some nations have capitalized on the unmet international demand for fertility services by allowing hubs of reproductive tourism to flourish within their borders.

Using reproductive tourism, in which people go abroad for assisted fertility services, as a case in point, this chapter examines the interaction of state policies, global markets, scientific innovation, and other forces of globalization in the transformation of reproductive practices. In debates about globalization’s effects on the movement and integration of capital, labor,

commodities, people, and services across national borders, the topic of reproduction is sorely understudied.

I present a moderate stance on globalization, seeing it as a transformative force that may produce beneficial and disadvantageous effects simultaneously. Globalization offers new opportunities and mobility at the same time it reproduces structural inequalities. Studies on the transnationalization of reproduction, for example, reveal new patterns of female migration, kinship structures, labor and childrearing that tend to empower those already privileged by gender, race-ethnic, class, and/or immigration status at the expense and exploitation of others (Ehrenreich and Hochschild 2002; Ginsburg and Rapp 1995).

This chapter examines how tensions between state control and individual desire are mediated by a global marketplace for assisted fertility services, paying attention to the patchwork of national policies regarding reproductive technologies in the face of multilateral trade agreements, regional confederations, technological development, and the forces of global capital. Using reproductive tourism as a case study, the focus will be on one central aspect of the globalization debate: to what extent has globalization presaged a declining role of the state? In other words, in a world where high-technology fertility clinics now advertise on the World Wide Web for an international clientele, does globalization make national oversight of reproductive technologies and services moot? Does it undermine the regulatory apparatus of the state, that is, its “governmental” power over population (Foucault 2007)?

POLITICAL DRIVERS OF REPRODUCTIVE TOURISM

International newspapers are filled with stories of individuals who have been stymied by their efforts to access reproductive technologies in their home countries because of such factors

as cost, restrictive regulations, or long waiting lists. The scenario of citizen turned global consumer may be illustrated by a case discussed in the *Guardian U.K.* concerning a British Asian couple (Ramesh 2006). The couple sought fertility treatment in England for six years before traveling to Gujarat, India, where they found an Asian donor-surrogate at half the price of what it would cost them at home, and who could be implanted with more embryos than is allowed under British policy. Had the couple used an egg donor-surrogate within the U.K., the surrogate would have had a right to reclaim the child during the first two years of its life, but in India, she has no rights to the child.

The couple was thus able to circumvent both the material and governmental conditions of their home country: by choosing a surrogate mother in India, they were assured a supply of Asian ova, cheaper services, multiple embryo transfers (to assure a greater chance of pregnancy and live birth), and sole parental rights. Despite the fact that the United Kingdom regulates reproductive technologies, this couple could bypass their own government's policies. In this case, self-interest trumped national law. In the case of the woman who became this couple's surrogate, she was subjected to practices that would not have been tolerated had she been a British, rather than Indian, citizen: a high risk multiple embryo transfer, no parental rights, and less compensation. Lack of regulations does not protect reproductive laborers from exploitation, but it does enable some people to have the children of their dreams. Lack of regulations is also good for business and local economies; fertility clinics in such places as India, the United States, or Spain, which have less restrictive policies regarding reproductive technologies than other nations, are able to—and expressly do—market themselves to a niche clientele seeking to bypass what they see as overly restrictive policies and/or overly expensive services.

From “test tube babies” to “designer children,” technologies that at first seemed impossible, unthinkable, or untenable are now available at fertility clinics throughout the world. The buying and selling of reproductive parts and labor is a thriving industry (Spar, 2006). The increasing existence and availability of technologies does not suggest, however, that medically assisted reproduction is universally accepted; cultural lag exists in that these rapidly changing technologies continue to raise many ethical questions, including how nations, professionals, institutions, and individuals should respond to them. In Chapter 4, I elaborate on how these ethics are expressed and put into practice by fertility industry professionals in the United States, and how this relates to ideals of both professional and reproductive autonomy.

Because cultures vary in terms of kinship structures, ethics, attitudes towards science and technology, the autonomy of medical institutions, and tolerance of government regulation, the way that states attempt to intervene and create norms to deal with new technologies and their accompanying ethical dilemmas will ultimately vary (Bandarage 1997; Callahan 1995; Kabeer 1996; McNeil 1990). In addition to policy variation among states is the internal variation of ethics, morals, interests, needs and desires within countries. The ethics inscribed in policies may reflect a position concerning liberties, rights, and autonomy that differs from those held by groups and individual members of the populace (Blyth and Farrand 2005). This is evident in debates surrounding abortion and stem-cell research, but it is also present in policies regarding assisted reproductive technologies.

When theorizing the ethics of reproductive technologies and the contradictions between state policies and individual desires, one must take care not to equate lack of regulation with more freedom and choice, and regulation with constraint. On the issue of “choice” and procreative liberty, access to reproductive technologies have generally not been touted as a

feminist issue of reproductive freedom, nor is there a unified feminist response. Firestone (1970), for example, early on envisioned that reproductive technologies could be used as a tool to liberate women from the birth process and the corollary responsibility of childrearing, whereas at the other end of the spectrum Corea (1985) equated reproductive technology with high-tech prostitution and the degradation of women. Feminist scholars writing about the traditional arenas of reproductive rights—abortion, birth control, and sterilization abuse—have noted the limitations of the “choice” frame (Cornell 1995; Petchesky 1990; D. E. Roberts 1997; Solinger 2002), and this frame is similarly problematic for reproductive technologies (Holland 2007; McNeil 1990; Rothman 2000). In the reductive and consumerist “choice” frame, every choice is equally valid and devoid of social, political, and economic context that renders some choices more possible, tenable, desirable, or commendable than others.

Additionally, access to reproductive technology may also get framed as a rights issue. Deech (2003), for example, notes that restricting individuals’ access to reproductive technologies may be construed as a violation of human rights. Like the “choice” frame, a human rights framework is also tricky. Although “human rights” may be touted as a cultural universal irrespective of national borders, states have different interpretations of what constitutes a right and even, for that matter, what constitutes a “human”—raising questions about *which* humans’ rights must be protected. Germany’s Embryo Protection Act, for example, accords embryos with the same status as born human beings, and thus regards some forms of reproductive technology, such as preimplantation genetic diagnosis, as violations of the embryos’ human dignity. In the United States, there is no federal standard for what constitutes personhood, but initiatives to define fertilized eggs as persons have been proposed in several states (Associated Press 2011a; Banks 2011; Graham and Peres 2007; Wetzstein 2010). These definitional distinctions not only

have implications for abortion, contraception, and stem cell research, but may have widespread consequences for the entire field of reproductive medicine. In the face of countries grappling with these complicated policy and semantic issues looms a growing global marketplace for reproductive technologies, services, and products.

INDIVIDUAL INTERESTS, NEEDS, AND DESIRES

Infertility may have been the initial impetus for the research and development of reproductive technologies such as sperm, egg, and embryo donation, surrogacy, and IVF, but they have since been put to other medical and social uses. Once reproductive parts, services, and labor have been commodified for individual consumption, the drive to expand markets leads to new uses, new demands, and an expansion of the very definition of “infertility” itself (as exemplified in Chapter 6). For some individuals, the demand for reproductive technologies stems from a desire to bear and raise a child who shares a genetic tie, or to undergo the physical experience of pregnancy and childbirth. For others, the desire is to reproduce not just any child, but a particular kind of child with a particular set of traits. (See Chapter 5 for further discussion about these culturally-inscribed desires).

Infertility as such may appear to be primarily a problem on an individual level: when people desire to reproduce, bear, and/or raise children, and cannot do so without medical intervention, infertility can be devastating. While some may choose to remain childless, others may adopt, while still others may decide to rely upon science, medicine, and technology to help them to bear a child. The industry that has developed to address the reproductive needs of the infertile is tremendous: Spar (2006) estimates that in the United States alone, the market for fertility treatment in 2004 yielded almost \$3 billion in revenue (3).

On an individual level, potential consumers of assisted fertility services have their own interests, needs, and desires to use the technologies that they find appropriate. Yet these potential consumers are also citizens, subject to their country's rules and regulations. Those rules and regulations are framed, in turn, by the interests of the nation in managing its demographic needs and reinforcing its ethical, cultural, religious, economic, and political norms and values. One can look to literature regarding population control, abortion, and birth control policies for examples of this governmental function (Kabeer 1996), or, as is argued here, one can also look to policies regarding reproductive technologies.

A problem arises when the interest of individual citizens clashes with national interest, when, for example, a lesbian couple is denied access to artificial insemination, or when a couple desiring a son is forbidden from using diagnostic tools to increase their chances. It is at this contradictory juncture of interests, needs, and desires that globalization, and reproductive tourism, specifically, enters. Globalization forces us to push the level of analysis up, beyond the state. Use of reproductive technologies has already been turned into an act of consumption, and globalization widens the market, pushing reproductive decision-making onto the global stage.

REPRODUCTIVE TECHNOLOGIES AND THE STATE

Government intervention and regulation of reproductive technologies does not necessarily indicate that the state has ultimate control of its members' reproductive decision-making; it does however indicate that it continues to maintain an interest in the interplay of demography and technology with culture and ethics. Legislative and ministerial regulations in individual countries or sub-national communities may outright ban certain forms of technologies or procedures regarded as morally repugnant, such as genetic screening of embryos, sex

selection, or commercial egg donation. Others may attempt to impose limits on who should have access to reproductive technologies, in terms of marital status, age, sexual orientation, and infertility status, while other guidelines attempt to regulate the anonymity of gamete donation. At one end of the spectrum are countries such as the United States, which imposes no comprehensive federal regulations concerning reproductive technologies, and at the other end are those such as Germany, whose parliament has enacted strict guidelines. Most countries fall somewhere in between these two poles.

There is presently a crazy quilt of services, regulations, and markets that vary from country to country. An infertile couple residing in Canada will have access to an entirely different range of services from one residing in Japan or Slovenia. Even within regional federations such as the European Union, there is not one standard guideline to which all member nations follow, but rather a patchwork of disparate regulations. In order to wrap our minds around some of the intense variability, what follows is a brief discussion of the role of the state in assisted fertility services in four nations: Germany, Israel, the United Kingdom, and the United States.

These four specific countries illustrate the range of regulations that are currently in place, and are representative of other nations' policies. While they are not strict "ideal types," they loosely adhere to four modes of biopolitical regulation: conservative (Germany), pronatalist (Israel), liberal (UK), and laissez-faire (USA). Israel and Germany offer excellent counterweights in terms of their international reputations for embracing and rejecting reproductive technologies, respectively (Hashiloni-Dolev 2007; Hashiloni-Dolev and Shkedi 2007). Although the United Kingdom and the United States are both regarded as liberal states, their divergence in policies is noteworthy.

Germany has by far one of the strictest policies regarding the uses of assisted fertility services. The basis of Germany's policy lies in the Embryo Protection Act (*Embryonenschutzgesetz*), adopted by the *Bundestag* in 1990, which imposes limitations on (including criminalization of) the uses of reproductive technology, human germ line cells, cloning, and the creation of human-animal hybrids. Scientists and doctors who violate the terms of the Act may be punished by fine or imprisonment for up to three years. Regarding reproductive technology, Germany permits in vitro fertilization and artificial insemination, but forbids egg donation, embryo donation, and surrogacy; it also limits the number of embryos that may be transferred to a woman's uterus, forbids sex selection with the exception of cases in which severe sex-linked genetic illness is to be prevented, and forbids unmarried or lesbian women access to assisted fertility services. Preimplantation genetic diagnosis and stem cell research are also prohibited (Bundesministerium der Justiz 1990; Jasanoff 2005a, 2005b; Robertson 2004).

In stark contrast to restrictive Germany, Israel is widely regarded for its pronatalist embrace of reproductive technology and fertility research. In 1987 Israel adopted National Health Regulations regarding IVF (Kahn 2000:75). IVF, artificial insemination, and egg donation are all permitted, with some limitations. Commercial and altruistic egg donation is forbidden; only surplus eggs from other women who had previously sought medical treatment for infertility may be donated. There are also many guidelines regarding consent and the marital status of all parties involved with gamete donation and embryo transfer (Kahn 2000). Although the 1987 guidelines initially forbid surrogacy, this restriction was overturned in 1996 when the *Knesset* adopted the Embryo Carrying Agreements Law, which permitted surrogacy agreements subject to the approval of a public committee (Ghent 1998; Kahn 1998). Unmarried women may

access IVF, but are restricted from using donated eggs or a surrogate (Kahn 1998, 2000). As of 2005, Israeli patients may apply to the health ministry for permission to choose the sex of their child through preimplantation genetic diagnosis if they already have four children of the same sex (Siegel-Itzkovich 2005:1228).

The United Kingdom's policies are guided by the Human Fertilisation & Embryology Authority (HFEA), which was established in 1991 within the Department of Health (Morgan 2004). Recently, the Public Bodies Bill seeks to transfer some of the regulatory functions of the HFEA to the Care Quality Commission (CQC) and other government bodies, but it has yet to pass through the legislative process (Human Fertilisation and Embryology Authority 2011b; Lord Taylor of Holbeach 2011). The Human Fertilisation and Embryology Act of 1990 provides guidance to licensed clinics regarding patient assessment, the welfare of any children resulting from treatment, consent procedures, and donor screening. The Act places age limits on gamete donors and recipients of services, forbids payment to egg donors beyond "reasonable expenses," forbids sex selection except in cases of medical necessity, limits the numbers of embryos that may be transferred during one cycle, and permits prenatal screening and preimplantation genetic diagnosis (Office of Public Sector Information 1990). Guidelines are continually being updated and reassessed, such as an expansion of availability of preimplantation genetic diagnosis for a wider number of genetic conditions (C. Williams et al. 2007), and a recent prohibition on anonymous gamete donation.

Finally, as I describe in detail in Chapter 3, the United States stands out because of its lack of comprehensive federal regulation of assisted fertility services (Spar 2006). Rather than the federal government sanctioning procedures, access to reproductive technologies falls primarily under the jurisdiction of state legislatures and courts. Currently, local policies vary

tremendously in the United States in regard to insurance coverage of infertile patients, parental rights of gamete donors and surrogates, use of surplus gametes and embryos, and the legality of surrogacy agreements (National Conference of State Legislatures 2007, 2010; Waldman 2006). With a paucity of federal and state law, regulation of the fertility industry in the United States is largely left to voluntary and non-binding self-policing by professional bodies such as the American Society for Reproductive Medicine (ASRM) and the Society for Assisted Reproductive Technology (SART).

The United States may be described as *laissez-faire* or perhaps more accurately “neoliberal” in its reproductive technology policy not because no laws exist at all, but because of the lack of one central policy or ethical guidepost, and its large reliance on industry self-regulation and market forces.⁵ In the United States, procedures that are prohibited in other nations are permitted, such as surrogacy, sex selection, large sums paid to egg donors, and services to unmarried women, lesbians, and women over the age of 45. Because assisted fertility services are largely guided by market, rather than state forces, access to reproductive technology is circumscribed by what the market offers and by patients’ health insurance status and/or ability to pay rather than by intervention or interference by the federal government. Even when regulations exist at the local level, those patients privileged enough may engage in within-country reproductive tourism, and travel to another state to procure the desired service or commodity. Considering the United States as a whole, the net effect is ultimately one of non-regulation.

⁵ This argument follows from Harvey’s (2006) definition of neoliberalism, which includes the idea that “State interventions in markets (once created) must be kept to a bare minimum because the state cannot possibly possess enough information to second-guess market signals (prices), and because powerful interests will inevitably distort and bias state interventions (particularly in democracies) for their own benefit” (145).

Table 1.1: Availability of Reproductive Technologies in Four Countries¹

	Germany²	Israel³	UK⁴	USA⁵
In vitro fertilization (IVF)	Yes	Yes	Yes	Yes
Embryo donation	No	Yes	Yes	Yes
Surplus egg donation	No	Yes	Yes	Yes
Paid egg donation	No	No	No	Yes
Anonymous gamete donation	No	Yes	No	Yes
Sperm donation	Yes	Yes	Yes	Yes
Surrogacy	No	Yes	Yes	Yes
Available to unmarried women	No	Yes (with limitations)	Yes	Yes
Available to lesbians	No	Yes (with limitations)	Yes	Yes
Age limits	N/A	Yes	Yes	No
Non-medical sex selection	No	Yes	No	Yes
Pre-implantation genetic diagnosis	No	Yes	Yes	Yes
Limit embryo transfer	Yes	No	Yes	No
Permit posthumous insemination	No	Yes	Yes	Yes
National insurance coverage	Yes	Yes	Yes	No
National oversight	Bundestag	Ministry of Health, Knesset	HFEA	FDA, CDC

Sources: 1. Jones et al. 2007; 2. Bundesministerium der Justiz 1990; 3. Kahn 2000; 4. Office of Public Sector Information 1990; 5. Jones et. al 2007

As Table 1.1 illustrates, there appears to be little consistency among Germany, Israel, the United Kingdom, and the United States. Although in vitro fertilization is permitted in each of the sample countries, policies vary in terms of who has access to the technology, where the gametes necessary for the procedure can be obtained, and what sort of regulatory oversight the state has, not to mention how the expense of assisted fertility services varies in each country. That services—however limited or restricted—are available in the above four countries is also significant, as most countries in the developing world cannot offer the same services (Nachtigall 2006).

The four countries described above have each followed a different path to regulation, and it is outside the scope of this chapter to address the cultural and political nuances behind each

policy decision, beyond remarking that other countries with similar ideological, moral, and/or historical milieus may be more likely to align with a conservative, pronatalist, liberal, or laissez-faire type (Jasanoff 2005a). However, because every country is unique in its own right, we may expect to see a continued diversity of regulations, unless globalization proves to be a convergent force. Most importantly, while the state has an interest in the reproduction of its citizens, and the means by which its citizens may need fertility assistance, the citizens' *own* needs and desires may diverge from national mandates. In the age of globalization, the actions of citizens may sometimes supersede the regulatory arm of the state.

THE DIMINISHED ROLE OF THE STATE?

Government's role in circumscribing, supporting, or ignoring citizens' access to reproductive technologies within the borders of their political communities both contradicts and upholds the tenet that globalization is decreasing the power or reach of the state. On the one hand, states attempt to exert power over reproductive decision-making by enacting and enforcing rules regarding reproductive technologies. On the other hand, reproductive tourism sheds light on the fact that despite national regulations, those citizens with the economic, social, and political means to leave the borders of their home countries have the ability to bypass the cultural, ethical, and legal restrictions that the state tries to impose on them. The question arises, then: what is the point of countries enacting guidelines specific to their own cultural and national communities if some individuals can choose to ignore them and seek fertility services in another country?

Reproductive tourism reflects a conflict between individual consumer desire and the state. Globalization serves to mediate this conflict, by offering an "out" to privileged consumers, and it also serves to heighten it, by highlighting the apparent contradictions among states. That

is, media, communications, and technology such as the Internet provide a forum for the global consumer to learn about a wide range of services available throughout the world; conflict arises when consumer demand for services does not match the availability and opportunity within one's particular country.

National governments risk increasing reproductive tourism as an unintended consequence when they attempt to change their policies regarding reproductive technologies in a more prohibitive direction. For example, when the United Kingdom's Human Fertilisation and Embryology Authority (HFEA) forbade anonymous gamete donation in 2005, the pool of willing donors, and thus the supply of available ova for in-vitro fertilization, declined. A number of articles in British newspapers subsequently reported that after this ruling, twice as many British couples are now going abroad to other countries such as Spain or Slovenia to procure eggs, possibly numbering in the thousands (Burne 2006; Fracassini and Bowditch 2006).

Another question arises as to the state's ability to monitor and regulate reproductive tourism itself, and whether this infringes on individuals' human rights and reproductive autonomy (Blyth and Farrand 2005; Deech 2003). This could involve government intervention such as denying visas, or punishing consumers who accessed forbidden reproductive technologies abroad. Reigning in reproductive tourism also poses a difficulty because of existing treaties and trade relations among nations. This is particularly relevant among member nations of the European Union, which guarantees the free movement of capital, goods, services, and people (Storror 2005). Beyond the European Union, the ability of other nations to police the movement of its populace for tourism purposes may be governed by multilateral trade agreements, migration and homeland security policies, and intergovernmental organizations.

The spirit of globalization and multilateralism facilitates reproductive tourism, and may in fact undermine the power of the state to regulate the uses of reproductive technologies by its citizenry. This diminished power, however, is stratified, intranationally *and* internationally. That is, reproductive tourism is not an option freely available to all. It necessitates a commitment on the part of a government to the free movement of people, goods, services, and capital, and thus demands a modicum of collusion on the part of the state and a sanctioning of interstate travel and commerce. Absent that commitment and collusion, reproductive tourism cannot take place; those individuals living in authoritarian states, for example, may be more restricted from engaging in reproductive tourism than those in democratic states.

Even within democratic states that allow for the free movement of citizens, the possibility of reproductive tourism remains bifurcated and limited to those who can afford to do it. Globalization makes it easier *for a privileged few* to cross borders in search of services or reproductive commodities unavailable or too expensive in their own countries, but it is not the great equalizer. Wealthy, elite, and/or privileged consumers will have an easier time globetrotting in search of reproductive technologies than the poor or less educated. Those who are constrained by material circumstances are the ones most constricted by their government's regulations and ideologies around reproductive technologies. For those without the ability to subvert their country's restrictions, the power of the state remains strong. Local inequalities become reenacted and reinforced on the global stage. The global citizen may transcend the state, but that global citizen is a member of the tiny elite not representative of the majority of the world. Therefore, on the question of whether reproductive tourism supports the contention that globalization is leading to the diminished role of the state, one can answer that in this case, the effect is limited and not universal.

SETTING GLOBAL STANDARDS

The fact that regulations currently vary widely throughout the world does not mean that there will not be a convergence in policy at some point in the future, possibly beginning with regional federations such as the European Union. The European Parliament and the European Union Council, in fact, approved a Human Tissues and Cells Directive on March 31, 2004, “on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells” (European Union 2004:48). Although it strives to set a regional standard, the Directive does not diminish the sovereignty of Member States. It stresses European cultural universals such as protection of human rights and human dignity, safety, and informed consent, but the section on Implementation specifically states that Member States may choose to enact more stringent guidelines (Article 4, p. 52). It is therefore not a universalization of Member States’ policies, but is instead a baseline of minimal regulation.

For example, the Directive speaks of anonymity and compensation for donation of human tissues and cells. “As a matter of principle,” states Paragraph 18, donation should be voluntary, unpaid, anonymous, and altruistic, and therefore, “Member States are urged to take steps to encourage a strong public and nonprofit sector involvement in the provision of tissue and cell application services and the related research and development” (p. 49). Note that this paragraph does not *order* Member States to forbid compensation or anonymity for donors, but rather *urges* them to do so. In fact, Article 12 states “Member States define the conditions under which compensation may be granted” (p. 54).

As this example illustrates, the Directive of the European Parliament and Council of the European Union provides regional quality and safety standards, as well as ideals for Member States to strive for, but it leaves room for individuality in Member States' policies. In this respect, aspects of the Directive are less stringent than the Council of Europe's 1997 Oviedo Convention on Human Rights and Medicine. This Convention, which, as of 2008 has been ratified by only 21 out of 47 member states, outright forbids sex selection for social purposes (Article 14), and prohibits financial gain arising from the disposal of the human body or body parts (Article 21) (Council of Europe 1997).

The Human Tissues and Cells Directive has already had an influence on how the United Kingdom's Human Fertilisation and Embryology Authority (HFEA) deals with reproductive tourism. If people wish to import donated sperm, eggs, or embryos from another country within the European Union, that country must have implemented the standards outlined in the Directive, the donated materials must be screened in accordance with the HFEA's own requirements, and foreign donors, like British ones, must be identifiable and receive compensation only for reasonable expenses. For sperm, eggs, and embryos donated from countries not part of the E.U., the patients' clinic must apply to the HFEA for a Special Direction, and again, adhere to the HFEA's guidelines (Human Fertilisation and Embryology Authority 2009a). While the HFEA and the E.U. Tissues and Cells Directive have consequences for the importation of reproductive commodities, they do *not* prevent British reproductive tourists from traveling abroad themselves in search of services (Human Fertilisation and Embryology Authority 2009b). By universalizing some procedures, regional standards such as the Human Tissues and Cells Directive may reduce some forms of reproductive tourism *within* the European Union, but may actually increase the practice of reproductive tourism by European citizens to non-E.U. states.

Intergovernmental and nongovernmental organizations may be another source of global standards. For example, the World Health Organization (WHO), United Nations Educational, Scientific and Cultural Organization (UNESCO), and World Medical Association (WMA) have each released statements addressing global bioethical standards for reproductive technologies and infertility treatment (United Nations Educational, Scientific and Cultural Organization (UNESCO) 2005; Vayena, Rowe, and Griffin 2002; World Medical Association (WMA) 2006). Yet each statement provides only a baseline of ethical practice, rather than a convergence or harmonization of regulations. Declarations by UNESCO, the WHO, or the World Medical Association do not preclude the possibility of countries violating their terms. As with any “universal declaration,” the universality of global standards may prove to be stratified, in which some states act as signatories and/or enforcers, while others flagrantly abuse them. Furthermore, maverick physicians and scientists may continue to practice in ways that their colleagues or their governments disapprove of, and if restricted from practicing in one locality, have the possibility of offshoring, and moving where the same regulations do not apply.

Another model of convergence that nations may want to consider is the Hague Convention on the Protection of Children and Co-Operation in Respect of Intercountry Adoption (more familiarly known as the Hague Adoption Convention), a multilateral agreement monitoring transnational adoption practices among over seventy nations. This international law sets baseline, universal standards for adoptions occurring between participating countries to ensure that full, informed consent has been freely given, and that the best interests of the child are met. The Convention also includes provisions mandating that countries establish a Central Authority to keep records, enforce rules, accredit service providers, and communicate with its international counterparts (Hague Conference on Private International Law 1993).

The Adoption Convention, which already acknowledges the reality of the transnationalization of reproduction, may be a potential model for dealing with reproductive tourism. Both transnational adoption and reproductive tourism reveal the geographic ends to which people will go in order to form families, and both are rife with ethical dilemmas and potentials for abuse and exploitation. At the very least, the Hague Adoption Convention acknowledges that as long as intercountry adoption is a reality, international regulations may help to stem abuses such as kidnapping or the trafficking of children.

Applying international law to reproductive tourism may be a way to ensure that the exercising of one person's right to use technology to have children does not infringe on another's health and well-being. Provisions mandating the establishment of a central authority in each signing country may presage the formation or identification of a national regulatory body in those countries that currently lack one. Although a Convention on Reproductive Tourism would probably encounter backlash from the fertility industry in laissez-faire countries such as the United States, it may still be in those countries' interest to sign in order to continue to attract fertility clinic patients from other signing countries. At the very least, it may begin a conversation about whether adoption of national policies regarding reproductive technologies is warranted or even constitutional.

CONCLUSION

Even if international standards are adopted, it is doubtful that reproductive tourism will disappear. Although some practices such as multiple embryo transfers, exorbitant compensation for egg donation, or sex selection could conceivably be banned by international law, the global marketplace and the demand for reproductive technologies already exists. Furthermore, the pace

of scientific innovation may prove to be a step ahead of regulation, with new procedures and services arising as older techniques are banned or standardized. While international standards may not stem reproductive tourism, nor modify the stratified nature of it, they may at the very least ameliorate some of the potentials for abuse and exploitation associated with reproductive technologies. Something like a Hague Convention on Reproductive Tourism would acknowledge the twin forces of technology and globalization that have utterly transformed procreation.

As Held and McGrew (2002) write, “Since a substantial proportion of the world’s population is largely excluded from the benefits of globalization, it is a deeply divisive and, consequently, vigorously contested process. The unevenness of globalization ensures it is far from a universal process experienced uniformly across the entire planet” (1). Examining reproductive tourism as a case study highlights this very unevenness of globalization. Although the practice of traveling the world in search of cheap, efficient, and safe assisted fertility services and goods may appear to be a free-for-all in which reproduction and conception have become truly transnationalized, this is not, in fact, the current state of affairs. By discussing reproductive tourism in the context of globalization, what becomes clear is how stratified this practice is. That is, an elite few are able to bypass the laws and culturally-inscribed ethics of their own particular country by way of the global marketplace and interstate travel and commerce, yet because of material and political realities, the majority of the world do not have this privilege and freedom.

Reproductive tourism can inform us about the uneven and limited nature of globalization; that is, we are not all equally affected. Globalization may help an elite infertile Japanese couple learn about and patronize a clinic in California that can assist them in locating a suitable egg donor, but for those who cannot afford tens of thousands of dollars for treatment on top of travel expenses, infertility and childlessness may continue to be a reality that cannot be overcome.

Infertility can be devastating to anyone, but the elite are better equipped to access services in their own countries and, if that is insufficient, to seek them abroad.

A consequence, then, is the reproduction of inequalities on both a local and a global level. This consequence becomes highlighted even more so by those reproductive tourists who seek assisted reproductive technologies for reasons besides infertility treatment. Whether it is to avoid the birth of children with defects or disabilities, or to produce “designer” children, the elite have greater access to these services, too. And, if a nation acts to prevent this genetic stratification of its populace by restricting reproductive technologies, the elite can access them in some other country where those restrictions do not exist.

Globalization produces a global citizenry, but this global citizen who transcends borders—political, economic, or cultural—is a tiny minority. Recall the pop star Madonna, an American-born citizen who went to Malawi to adopt a child to bring back with her to England. “Belonging” to no single country, she successfully subverted adoption procedures in three nations (O’Shea 2007).

Globalization has prefigured the very possibility of reproductive tourism, if only for the elite. Without global standards in place, the practice will probably continue, and inequalities will continue to persist. Technology has given us brand new ways to conceive and bear children that go beyond the limits of the body. What globalization has given us are even more ways to conceive and bear children that go beyond the limits of national and cultural boundaries.

Chapter Two

The Logic of Reproductive Tourism: The United States as Destination

Reproductive tourism is a subset of medical tourism that, in addition to bargain hunting, is also driven by public policies that ban or restrict access to particular reproductive technologies. By focusing on the high cost of fertility services alone, researchers and journalists neglect to parse the non-economic factors driving reproductive tourism and, as a consequence, neglect entire regions—such as the United States—where this practice is currently prevalent. Reproductive tourism must be examined through the lens of political economy, but zeroing in on market relations should not come at the expense of political analysis.

Consider the following three scenarios:

- A) An American heterosexual married couple would like to obtain the services of a gestational surrogate because the wife is unable to carry a pregnancy to term. Unfortunately, the costs of using a surrogate in the United States can cost upwards of \$80,000 to \$100,000, which is out of their financial reach. The couple travels to Mumbai, India, where the price of surrogacy is as much as 75% cheaper.
- B) A gay male couple in France would like to obtain the services of a gestational surrogate and an egg donor in order to have a child. Unfortunately, compensating egg donors and surrogates is not legal in France. The couple travels to Los Angeles, CA, where egg donation and surrogacy are both legal.
- C) An Argentine couple has been trying to have a child for several years. Unfortunately, they have not had any success with treatments from local fertility doctors. The couple, after searching on the Internet, finds a clinic in New York City that boasts of a new technique with excellent success rates, and several staff members who are fluent in Spanish.

In each example, “reproductive tourism” describes quite different circumstances—economic, political, and medical. Is it accurate, then, to apply the same set of analyses to such different circumstances?

Based on in-depth interviews I conducted with fertility industry professionals (including physicians, fertility clinic staff, attorneys, and egg donation and surrogacy coordinators) in New York City, Los Angeles, and San Francisco, I theorize three motivations for reproductive tourism: (1) the logic of the bottom-line, or traveling to other countries in search of cheaper services, (2) the logic of personal autonomy, in which individuals seek services that are outlawed or highly regulated in their own countries, and (3) the logic of global consumption, in which services are sought on the basis of success rates, reputation, quality of care, or special benefits, regardless of cost or location. I argue that mainstream media and scholars, by overwhelmingly writing about and studying Westerners who travel to India for surrogates, are overly focused on the logic of the bottom-line. While this narrative is compelling, it cannot explain why the United States has become a hub for reproductive tourists from less wealthy nations.

In the logic of the bottom line, individuals and couples travel to another country to acquire assisted reproductive services for financial reasons. The typical scenario, exemplified by the first hypothetical, involves a couple from North America or Western Europe who travels to India for an IVF surrogate because services are so much cheaper there. This logic fits rather nicely into contemporary discussions of medical tourism, such as traveling abroad for cheaper dental or knee surgery.

The second logic of reproductive tourism is “the logic of personal autonomy.” In this logic, individuals and couples travel to other countries to acquire services that, because of policies in their own countries, are unobtainable or difficult to access. The typical scenario, exemplified by the second hypothetical, is an individual or couple residing in one of the many countries throughout the world with restrictive policies concerning reproductive technologies

(that is, most of Western Europe, Japan, Australia, and Canada, among others), who travels to the United States for egg donation, surrogacy, or sex selection.

The third logic of reproductive tourism is “the logic of global consumption.” In this scenario, typified by the third hypothetical, consumers respond to sets of benefits and advantages offered by competing regional fertility markets: perks, personal attention, reputation, success rates, and cutting-edge technology, among other factors. Because assisted fertility services are quite expensive, and are not likely to be covered by insurance policies when consumed transnationally, those who pursue these services will be largely limited to relatively affluent individuals. In a global marketplace with open borders—particularly for the affluent and well-connected—consumption is not regionally bound. Consumers may seek out information, weigh their options, and ultimately decide to acquire assisted fertility services in the country that best fits their needs.

THE LOGIC OF THE BOTTOM-LINE

“Price is always juicy.”

- Deirdre, family law attorney

Media reports about reproductive tourism tend to center around the logic of the bottom-line, perhaps because it fits most easily into already existing discourse about other forms of medical tourism (e.g. Carney 2010; Chen 2010; Fontanella-Khan 2010; Gentleman 2008; Hochschild 2009). This centering problematically obscures other factors driving the practice, and gives the impression that the majority of reproductive tourists are middle-class Westerners wanting to strike a bargain in poorer nations. As a consequence, mainstream discussions of reproductive tourism focus overwhelmingly on surrogacy markets in India, overlooking other

geographical regions such as the United States, as well as other forms of transnational fertility services, such as egg donation and sex selection. Furthermore, it implies that individuals desiring babies are rational actors, that Homo Reproductus is Homo Economicus—that is, that their decision-making is based on economic, rather than emotional, affective, or ethical terms.

Based on interviews I conducted with American fertility industry professionals, in which I asked them what brings their international clients to this country, it is clear that cost is generally not part of the equation. Fertility services are expensive. An IVF cycle in the United States averages over \$12,500 per cycle (G. M. Chambers et al. 2009), whereas a website for a clinic in the Czech Republic, for example, cites \$2259 (C. Fite and M. Fite n.d.). Egg donation costs, including fees for donors and brokers, in addition to payment to clinics for IVF, can add tens of thousands more dollars, and surrogacy even more so. The logic of the bottom-line does not determine why international clients come to the United States, but it may operate in the reverse trend of Americans who decide to go abroad.

Providers recognize that reproductive tourism to other parts of the globe exists and may draw some of their potential clients away. Rebekah, co-owner of a surrogacy agency, spoke of the cost differentials, where IVF cycles may cost \$4000 in Europe, but \$20,000 in the United States. If demand for their services were based on price tag alone, the United States fertility industry would be the loser on the international market. When potential clients compare the costs between nations, they may balk at how expensive services run within the United States. Los Angeles physician Dr. S tries to explain to his international patients who ask, “How can you charge so much for that?” that the difference in price relates to higher costs for malpractice insurance and licenses. He explains, “They have socialized medicine. You come from London,

they think you can break your arm and walk in and just get it set and walk out paying \$5. It just doesn't work that way here.”

The extreme difference in price means that American fertility providers do not compete on the basis of cost. “Price is always juicy for people,” says Deirdre, a San Francisco lawyer. “The majority of people are looking at price, and \$20,000 [for IVF] is significant.” She and other providers I spoke with clearly understand the logic that drives reproductive tourism to India and Eastern Europe. Linda, for example, spoke of a couple that had decided to go to Pakistan “Because it’s going to hardly cost her anything.” When clients decide that it will be cheaper for them to go abroad, Linda says the doctors may try to dissuade them by informing them about differences in technology or success rates.

Although some may be skeptical about the quality of care in other countries, others did not see a problem with it. As Dr. H put it, “I think as long as, say, the people in India do this very well, it’s fine. As long as it’s done carefully, sensitively, responsibly, what difference does it make whether you use a gestational carrier in San Francisco or Delhi? I mean, it’s just somebody to help carry the baby that’s going to allow you to have a child and a family.” By framing the “gestational carrier” as some sort of disembodied vessel that can be located anywhere, Dr. H is able to justify the practice of traveling to another country to purchase a cheaper vessel.

The logic of the bottom-line is clearly driving much of the reproductive tourism going on today. For those who feel financially constrained, India or Eastern Europe provides a less expensive alternative than New York City or Los Angeles. Yet, because business is still booming in New York City, Los Angeles and San Francisco, other logics that go beyond the financial must be factoring into decisions by clients coming from abroad. Although the logic of the

bottom-line explains one of the patterns of reproductive tourism—from wealthy nations to less wealthy nations—it cannot account for reproductive tourism to these three United States cities.

THE LOGIC OF PERSONAL AUTONOMY

“I think we are kind of free to do more than most countries are, and that’s why people from other countries come here.”

- Jen, genetic counselor

By focusing so much attention on the logic of the bottom-line, the political motive for reproductive tourism gets overlooked, and entire fertility markets such as the United States are left out of the conversation. A burgeoning fertility industry exists throughout the world, largely in high and middle-income nations, with great variation in the number of clinics and agencies, scientific and technological resources, and types of services offered. Furthermore, there is an astounding variety of policies and laws regulating assisted reproduction. From highly regulated countries like Germany, to an almost complete absence of regulation in the United States, to more of a middle ground in places such as the United Kingdom, there is clearly no universal standard when it comes to reproductive technologies (L. J. Martin 2009; Spar 2005).

Reproductive tourists are coming to the United States from all over the world. When I asked my interview subjects from what countries their international clients hail from, many of them tended to reply something along the lines of, “They come from all over,” or “Everywhere.” When pressed for more details, some of them replied in broad terms, classifying their clients as coming from Europe, Asia, the Middle East, or Latin America, for example. Throughout the interviews I conducted in New York City, Los Angeles, and San Francisco, 35 specific countries were named as sending countries: Afghanistan, Argentina, Armenia, Australia, Belgium, Brazil, Canada, Chile, China, Dubai, Egypt, France, Germany, Greece, Hong Kong, India, Israel, Italy,

Japan, Korea, Kuwait, Mexico, Mongolia, New Zealand, Norway, Peru, Russia, Singapore, Slovenia, Spain, Switzerland, Taiwan, Thailand, the United Kingdom (or England), and Vietnam. Although “Africa” was named as a region from which a provider has seen clients, Egypt was the only nation in Africa specifically named.

By naming particular countries or states, the providers did not imply that they regularly see clients from all of the above countries equally. Some countries, such as Afghanistan and Mongolia, appeared to be named as one-off examples by providers to prove how “exotic” or widespread their client base is. Of the countries that were singled out by name, several were repeated throughout many interviews. Australia, for example, was cited in more than half of the interviews and, of those providers who mentioned Australia, many also expressed to me that they receive “tremendous” numbers of clients from that country. Japan, the U.K., China, France, Italy, Canada, and Mexico were the next most frequently cited in interviews. Of the large regions that were named, Europe, Asia, Latin America (and/or Central and South America), and the Middle East were named most often.

As one can see by the list of countries from which reproductive tourists travel, many of them are highly industrialized, democratic nations. Eighteen are members of the Organisation for Economic Co-Operation and Development (OECD). The remaining seventeen include Hong Kong and Taiwan, the BRIC nations (Brazil, Russia, India, and China), the oil-rich states of Dubai and Kuwait, and the developing nations Vietnam, Egypt, Mongolia, Armenia, Peru, Singapore, Thailand, and war-torn Afghanistan. Thus, although my interview subjects inform me that large numbers of international clients are traveling from Australia, Japan, and England, it would be false to make a blanket statement that reproductive tourism is only something practiced by citizens of wealthy, industrialized nations. Moreover, the narrative promoted in the

mainstream media and even in scholarly journals, that reproductive tourism is akin to neo-imperialism, in which wealthy Westerners travel to poorer regions to exploit the bodies of brown women, is also incomplete. The United States, one of the wealthiest, most developed countries in the world, is a receiving nation of reproductive tourism from the developed *and* the developing world.

That said, it is worth saying more about the eight most frequently cited countries: Australia, Japan, the U.K., China, France, Italy, Canada, and Mexico. Most notably, they span the globe, in four continents. Given that these countries were most frequently named in interviews as sending countries, it is useful to take note of the state of assisted fertility services in each country. That is, do these countries lack their own robust industry? Is a lack of trained physicians and fertility centers boosting reproductive tourism to other countries? The second column in Table 2.1 shows the number of fertility centers in each country as reported in a 2007 report published in *Fertility & Sterility* by the International Federation of Fertility Societies (IFFS), with the United States' numbers supplied for comparison.

Table 2.1: Absolute and per capita number of fertility centers in 9 countries

Country	Number of Fertility Centers (2007) ¹	Number of Centers per 1,000,000 people (based on 2010 population estimates) ²
Australia	75	3.5
Canada	16	.47
China	178	1.34
France	93-100	1.44-1.54
Italy	315	5.42
Japan	520-590	4.1-4.65
Mexico	40	.36
United Kingdom	80-119	1.28-1.9
United States	399-450	1.29-1.45

Sources. 1: Jones et. al (2007); 2: Population estimates from CIA World Factbook (2011)

In the third column of Table 2.1, I show the per capita ratio of fertility centers in each country per one million residents, calculated based on population estimates from the CIA World

Factbook.⁶ While the United States in absolute terms has one of the largest fertility industries in the world, boasting up to 450 fertility centers, Australia, Italy, and Japan have far more fertility centers per capita. China, France, and the United Kingdom have a comparable number of clinics per capita with the United States. On both an absolute and per capita basis, Canada and Mexico, the neighboring countries from which international clients have the least distance to travel, have far fewer fertility clinics than the United States.

Types of regulation vary from country to country, as well. The national regulation that exists in the United States is largely focused on laboratory protocol and consumer-oriented legislation mandating reporting of success rates. Although state-level legislation exists permitting or proscribing particular procedures, there is no national-level promotion or ban, unlike in many other nations. Surrogacy, egg donation, and sex selection, for example, are all procedures that are highly regulated if not outright banned in a plurality of countries.

According to providers I interviewed, it is not a lack of an adequate number of fertility clinics in their home countries that drives reproductive tourism to the United States. Rather than *quantity*, the issue appears to be one of *quality*, in that clinics in the United States offer services that cannot be obtained in their own countries, or because of United States clinics' technical superiority, as measured by their published success rates. The IFFS report contains data about a number of regulations that vary regionally (see Table 2.2). Of the eight countries, China, France, Italy, and Japan require that people seeking assisted reproductive technology be in married or stable relationships. Australia, Italy, Japan, Mexico, and the United Kingdom place limits on the number of embryos that may be transferred during IVF. China, Italy, and Japan forbid egg donation; Italy forbids sperm donation, and Japan only allows sperm donation when used with

⁶ The three-year discrepancy in dates between the two sets of data means that the per-capita ratio cannot be taken at face value; however, the numbers provide a generalized snapshot of the size of each country's fertility industry.

artificial insemination (i.e., not with IVF). Australia, China, and the United Kingdom do not allow anonymous gamete donation. Italy forbids all use of pre-implantation genetic diagnosis (PGD); France and Japan forbid the use of PGD to screen embryos for chromosomal abnormalities. France, Italy, and Japan do not allow gestational surrogacy (Jones et al. 2007). The United States federal law, by contrast, has no relationship requirements, no limits on embryo transfer, allows egg and sperm donation, PGD, and gestational surrogacy. As described in Chapter 3, the United States is not entirely laissez-faire: regulations are determined by state law, and professional organizations maintain practice guidelines for their members.

Table 2.2 Existence of national laws and policies regulating ART

Country	Relationship Status	Embryo Transfer	Gamete Donation	PGD	Surrogacy
Australia		X	X		X
Canada			X		X
China	X		X		X
France	X		X	X	X
Italy	X	X	X	X	X
Japan	X	X	X	X	X
Mexico		X			
U.K.		X	X		X
U.S.A.					

Source: Jones et al. (2007)

The logic of the bottom-line can at least partially explain reproductive tourism *from* the United States, but it cannot explain reproductive tourism *to* this country. That is, because assisted fertility services are so expensive in the United States, the financial motive is not an adequate explanation. Rather, we may look to the logic of politics and the enactment of personal autonomy as a major contributing factor. Because Australia was one of the most frequently cited, I will use it as an example to illustrate how Australian public policy drives reproductive tourism.

The case of Australia

Australia, along with the United Kingdom and the United States, was one of the first countries in the world to make major advances in research involving assisted reproductive technologies (Henig 2004). It is ironic that this country is so frequently named in interviews as a primary sending nation for reproductive tourism. Over the past several decades, Australia has developed a set of policies guiding fertility industry practices. Consequently, those consumers desiring particular kinds of assisted fertility services may no longer be able to acquire them—or acquire them as easily. Australia is an excellent case to illustrate the logic of personal autonomy: despite the geographic distance and the costs involved, Australians who travel to the United States for assisted fertility services may in fact do so in order to transcend the laws and policies that their own country has developed.

At the time of my interviews (summer of 2009), sex selection was generally unavailable in Australia, although there is currently discussion in Australia to reverse this trend (McArthur and Doherty 2010). In 2004, Australia's National Health and Medical Research Council instituted a ban on sex selection except in cases of serious genetic conditions; the ban is, however, more of a guideline than a legally binding protocol throughout the country (Feikert 2009). The states of Victoria, Western Australia, and South Australia have instituted their own stricter prohibitions on sex selection (*ibid*).

Prohibitions against and impediments to obtaining sex selection in Australia (among other countries) leads to inquiries by individuals desiring the procedure.⁷ During my interview with New York physician Dr. B, he happened to receive an email from someone in Australia. The doctor turned his computer monitor around to show me his email inbox, pointed at the screen, and said, “This was what I’m talking about. Referred from New South Wales, Australia, stating he wants gender selection. [*Reading from screen*] ‘The legislation in Australia doesn’t

⁷ Dr. S estimates that about 80% of his international clientele come to his clinic for sex selection.

allow such treatments and thought of taking it a step further.’ ... That’s their reason for contacting me! Not because I’m some super doctor.” Despite attempts in Australia to restrict sex selection, those with the desire and the wherewithal still seek those restricted services outside their country’s borders. Sex selection throughout the world is largely regulated, if not outright banned; therefore the United States offers one of the best options for those seeking this service, despite the geographic distance.⁸

Australia also extensively regulates gamete (sperm and egg) donation. Provisions by the National Health and Medical Research Council prohibit both anonymous and compensated donation (Australian Government 2007). Because Australia acknowledges the right of children to information about their genetic parentage, gamete donors must consent to having their identifying information released to any future genetic offspring. Additionally, families that do not want to disclose to their offspring the nature of their conception may want their gamete donor to be anonymous. Dr. C, a San Francisco physician, sees Australia laws about donors needing to identify themselves as creating “huge problems,” because children conceived through gamete donation are “going to find out about it through the state.” If they get their services in a country without these laws against anonymous donation, they can keep their medical records and the circumstances of their child’s conception private. “And that’s the way it should be,” says Dr. C, “because conception is a private matter between adults, and I don’t think the state has a role in that, except for perhaps safety issues.” Although this particular anecdote is about Australia, the situation applies to consumers from other nations with similar guidelines prohibiting anonymous gamete donation, such as the United Kingdom.

⁸ Traveling to relatively nearby New Zealand is not an option, as sex selection is banned there, with penalties of up to NZ\$100,000 for violation (S. F. Clarke 2009).

In addition to policies about anonymous gamete donation, Australia, like many other nations, does not allow gamete donors to be monetarily compensated. Article 6.5 of the Regulations states: “Do not trade in human gametes. Gamete donation must be altruistic. Commercial trading in human gametes and/or the use of direct or indirect inducements, must not be undertaken” (Australian Government 2007:27). As with bans on anonymous gamete donation, bans on compensating donors has also increased reproductive tourism from Australia, to the benefit of American providers. Dr. C told me that “the Australians emerged” as patients after laws restricting egg donation in Australia passed. “And we now have a reputation because we produce so many babies, ... that if people want to do egg donation, they come here to do it. It’s an easy trip. There are direct flights from Australia.”

Again, although the discussion here is limited to Australia, this scenario was echoed throughout my interviews with providers: all over the world, individuals reside in countries that have developed policies prohibiting compensating egg and sperm donors. By relying only on “altruistic” donors, countries attempt to impede the development of egg and sperm markets. Yet demand for sperm and egg donors outstrips supply, particularly when rules against donor compensation consequentially results in a limited pool to draw from. Egg donation, in particular, is a process that involves weeks of hormone injections, minor surgery, and medical risks such as ovarian hyperstimulation. Rather than rely on a pool of young women induced to donate their eggs by paying them thousands of dollars (as is common in the United States), donors in countries such as Australia are limited to other recipients of assisted fertility services who have excess gametes to donate, or friends and family members of the intended parents. This not only limits the *number* of gametes available for donation, but limits the *quality* of the gametes, particularly in terms of variation in physical characteristics and ethnic markers. This last point

about the quality of gamete markets will be further elaborated in the section on the logic of global consumption.

Finally, a third area of Australian policy that influences reproductive tourism out of that country and to places such as the United States is surrogacy. Similar to their guidelines on altruistic gamete donation, Australia bans compensation for surrogates. Article 13.1 states “Do not undertake or facilitate commercial surrogacy. It is *ethically unacceptable* to undertake or facilitate surrogate pregnancy for commercial purposes. Clinics must not undertake or facilitate commercial surrogacy arrangements” (emphasis added Australian Government 2007:57). All forms of surrogacy, commercial and altruistic, are prohibited in Queensland, Victoria, and Tasmania (K. Williams 2007). Noncommercial surrogacy is not prohibited in some Australian states, but even these arrangements are limited by federal guidelines. Furthermore, clinicians are forbidden from advertising surrogacy services or being compensated for facilitating surrogacy arrangements.

As with prohibitions on commercial gamete donation, prohibitions on commercial (and in some states, altruistic) surrogacy vastly limits the pool of available surrogates. This leaves the United States, once again, along with India and a handful of other countries, as some of the only global marketplaces where women are legally enabled to enter into a commercial surrogacy contract.⁹ Tammy, a social worker, believes it is “really a shame” that Australia has “every element that is important to do surrogacy”—that is, both the technology and the people willing to be surrogates—but many of its states’ policies against commercial surrogacy make those elements moot. She sees a *mismatch* between what individuals in Australia want, and what the country has decided is ethically normative. In order to exercise their desire for children through

⁹ New South Wales, attempting to prevent surrogacy tourism, recently enacted a law that will criminalize commercial surrogacy even when it takes place outside the country’s jurisdiction (Noone 2010).

commercial surrogacy, Tammy finds it only rational for them to come to the United States to do so—but that rationale is not based on economics, but on desire and political circumstance.

Individuals throughout the world face this mismatch between personal desire and government policy, and this mismatch is driving reproductive tourism. Whereas the logic of the bottom line assumes that services are similar, abundant, and widespread such that a consumer only needs to locate the cheapest place to get his or her reproductive needs met, the logic of personal autonomy points to *global variation* in regulation and availability. Not only do people need to be financially savvy in their search for assisted fertility services, they must also be savvy enough to navigate the laws in both their home countries and those they intend to travel to.

Indeed, the logic of personal autonomy may sometimes appear to be the logic of the last resort. From the perspective of the individual desiring a child by means of gamete donation, surrogacy, or IVF, traveling to another country and paying a higher premium may seem like the only option. Many providers, sympathetic to their clients' needs (and their credit cards), describe the situation by invoking the language of *necessity* or lack of options:

Linda (fertility clinic director of operations): It's illegal to do egg donation in other countries. You know, not all other countries, but some. So they have no choice if they want to have a baby but they're old, or they need an egg donor.

Tammy (social worker): It's pretty much a necessity. Most countries don't allow this. And, so, in order to, for this to be possible, they have to come to another country. And a lot of them choose California because ... we're some of the most established agencies. So, they don't really have a choice, unfortunately.

This discourse exemplifies some of the assumptions of “American exceptionalism” critiqued by Puar (2007), in that they not only describe American policies as unique, but also imply that they are superior. Lax regulation becomes a cognate for “freedom” and “choice” in the neoliberal language of the free market:

Liam (CEO of a surrogacy agency): It's pretty much illegal in their own country. Pretty

much surrogacy's not legal in any country around the world. And, their options if they didn't do it in the U.S., would be to do it in India or perhaps Russia, and in those countries they don't have the same protection.

Jen (genetic counselor): I think we are kind of free to do more than most countries are, and that's a lot of times why people from other countries come here, is because they can't get those services where they're from, whether it's that they have, you know, socialized medicine, or that there's religious issues related to reproductive medicine. But I think because we're open in both of those respects that people come here to get their services.

The case of alternative parenting

Although Australia serves as a good illustration of reproductive tourism being fed by policies limiting the types of services an individual or couple may access, there is another type of limitation evident in some other countries' policies: limiting not the type of services one can access, but limiting *who* may access them. People prevented from accessing types of assisted reproductive technology services include lesbians and gay men, single people, unmarried couples, and older people. For example, the IFFS reports that 36 out of 57 countries queried have statutes or guidelines restricting assisted fertility services to couples in married or stable relationships (Jones et al. 2007). Although individual clinics and providers, using their own discretion, may choose what types of people to work with, United States law does not forbid lesbians, gay men, single people, or people of advanced maternal or paternal age from consuming fertility services. Again, during interviews, providers cited these sorts of restrictions in other countries—particularly against gay men—as reasons why clients travel here from other nations for assisted fertility services.

THE LOGIC OF GLOBAL CONSUMPTION

“If they need an egg donor, you've got one kind. It's called Indian.”

- Anne, surrogacy agency program coordinator

Finally, the third type of logic of reproductive tourism speaks to consumption practices in the age of globalization, where consumers may consider a range of goods and services regardless of location and international borders. Given the advertising and information-sharing made possible by the Internet and other communications media, consumers may be aware of goods and services in locales hundreds if not thousands of miles away from them. Moreover, commerce, shipping, and high-speed travel options enable consumption on a global scale. This type of transnational consumption is not limited to imports; overseas travel itself is an act of transnational consumption, in which the consumer travels to the point of origin of the good or service.

Aside from bargain-hunting or evading government restrictions, savvy and discerning individuals driven by the logic of global consumption may take into consideration such factors as reputation, success rates, personal recommendations, and a host of perks and benefits that a particular clinic, physician, or other provider may offer to them. With such a delicate and high-stake transaction as assisted fertility services, consumers may wish to work with those providers who they believe are most likely to offer them the highest quality service and the greatest likelihood of success.

The competitive advantage of the United States

Assisted fertility services are not only available but are much cheaper in many other countries—surrogacy in India, for example, or egg donation in Romania—yet hundreds, if not thousands of people choose to come here for fertility services. Providers cited the quality, superiority, and safety of American health care as an explanation, especially as compared to services in other countries. Intended parents from abroad may not have first-hand experience that

Americans have high quality services, but with the prominence of the United States as a world power, and with its dominance in the global entertainment industry, they may be more willing to trust that assisted fertility services will be safe, and that the legal terrain will be above board. Dr. H told me that his international patients “need to be well taken care of. And they need to know what system they’re getting into. And how good that system is,” and it is a matter of faith for them that these needs can be met in the United States. At the same time, he concedes that this may be a false hope. Where quality and ethics are concerned, the country one chooses may not be as important as the individual clinic, and that “Where you’re going to end up is very important, relative to how good of a clinic are they, how ethical are they, how much money are you going to end up spending, that kind of thing.”

Providers also cited the quality of infertility treatment, technology, and services in the United States as a factor for their international patients’ decisions to come to this country. Several speculated that American success with assisted fertility is borne from decades of accumulated experience. Dr. M cites the higher success rates of fertility centers in the United States as a contributing factor, and ascribes success to higher quality and more experience. For those who are “really desperate” in their quest to conceive, proven success rates are often more important than any other factor, including cost.

Intended parents may also be concerned about the conditions for surrogacy and childbirth in other countries—either out of sympathy for the surrogates who will carry their babies, or for the outcome for the babies themselves. India again emerges as the foil for comparisons of reproductive tourism. Anne, program coordinator of a surrogacy agency, compares the quality of medical care between the two countries, arguing that in the United States, “everything is done properly medically,” but she does not trust that India can offer the same care in a field that is

laden with many potential risks—even though she does not actually have any firsthand experience or knowledge about surrogacy in India:

We have a lot of things that go wrong, medically. That's why these [American] doctors are the best in the world when they're looking at a high density ultrasound, and they can see that, "Oh, gee, there looks like a bubble on that baby's brain. Let's track that." This is part of our work. I doubt that's going on there [in India]. And, if a baby, ... needs a high-level NICU [neonatal intensive care unit], I doubt that's being provided. So, I think the overall medical care is highly questionable.

A second factor cited by providers is tied specifically to egg donation, and speaks to the racialized "genetic imperative" I analyze in Chapter 5. According to a number of providers, for patients who want an IVF surrogate and will provide their own fertilized egg (i.e. their own genetic material), India is a low-cost option. If they want or need to use an egg donor, however, the impression is that the United States has better quality in terms of "the selection of donors we have available for people" (Dr. C). As Anne bluntly put it, "If they need an egg donor, you've got one kind. It's called Indian." India is not the only country that providers compared their practice to. Dr. H describes how egg donation worked in Italy before the country outlawed it:

[P]atients came back to this country who told me they had been there, and it was very bizarre to me. They would call up and say, "Okay, we have some eggs here. Come on down," and then they'd say, "Oh well, maybe these eggs aren't right," you know, and you just wonder, what's the criteria for picking eggs, and what's the criteria for maintaining records, or knowing that this is a safe situation. You just really are concerned.

Liz, the egg donor coordinator at a large New York fertility clinic, also expressed curiosity about how donors are chosen, and cites a clinic in Spain that boasts 4000 egg donation cycles per year (as opposed to the hundred or so cycles per year at her clinic):

I was talking with one woman, and she said, basically, they constantly stimulate donors. They just don't stop. So they have however many donors stimulating at the same time, and then the patients just kind of come in and I don't think there's much matching that goes on—[here] we match one recipient to one donor. It's just kind of like, they're constantly stimulating the donors, so whoever's next in line gets their oocytes.

While it is not clear whether or not individuals actually decide to come to the United States because of the variety and quality of egg donors, this is, at least, the impression that providers have when they describe how the American fertility industry differs—or is superior to—industries in other nations. The very idea of *not* matching egg donors to intended mothers strikes some American providers as a bizarre practice. Dr. H, for example, verbally struggles over whether or not matching matters when an intended parent’s ultimate desire is to bring home a baby:

But knowing, I mean, I guess if you go somewhere and they say “Well, we’re just going to give you an egg, and you’ll get a baby,” and you have no choice, and there’s no—maybe it doesn’t matter. Who cares whether it came from one woman or a different woman? All you were going over there for was to get some eggs and hopefully have a baby. You had no say-so in who it was anyway. So maybe just shut up.

Yet, as he continued speaking, he went back to justifying why choosing particular eggs is important, rather than any “random” egg. Interestingly, rather than justify egg donor matching in order to produce similarity between parents and child, he spoke of the ability to produce (genetic) similarity between siblings.

As I discuss further in Chapter 5, within the United States, sperm and egg donors are matched with recipients for certain qualities or traits the agencies or the intended parents find important: race/ethnicity, religion, personality, hair and eye color, build, academic achievement, and so on. In that chapter, I discussed how Megan, marketing director of an egg donor program, describes how her agency screens potential donors with criteria based on what qualities they perceive clients desire. Donors are screened and matched by family’s health history, weight, how “bright” or attractive they are, personality, grades, school pedigree, or even how similar they appear to the intended parents. Megan is not uncritical of some of her clients’ choices and

desires. Later in the interview, she criticizes what she calls “genetic engineering,” that is, when people are “freakishly picky” about the precise qualities they want their children to have.

Screening and matching goes on at every egg donation program where I conducted interviews. Liz puts great value on her ability to find donors who resemble her clients. Speaking again of the clinic in Spain that boasts 4000 egg donation cycles per year, she is baffled by the idea that “the next person who walked in got the next donor’s eggs that were retrieved, regardless of what they looked like.” She cannot imagine matching donors to clients in such a random fashion, without taking into consideration race and body type. She sees this matching, even of similar interests, as a way to “help the recipient to connect with the donor, and make the process a little bit easier.”

The United States is not the only country with egg markets; there is also a booming egg market in Central and Eastern European countries such as Romania and the Czech Republic¹⁰. Yet as Anne’s quip about Indian egg donors hinted at, the very pluralism of the United States is a competitive advantage: the United States boasts young women of almost every conceivable hue, race/ethnicity, and religion. As Liz describes, the advantage that she has as an egg donor coordinator in the United States is that here “you have every possibility of finding [a donor] that looks like you.” Not only is there a high likelihood of finding a young white egg donor, particularly one who has the education and cultural capital that intended parents often desire, but there are also specific niches of Asian or Jewish egg donors, for example, that can be fulfilled.

A third advantage of coming to the United States for fertility services cited by providers is the clarity and/or ease in this country of establishing legal parentage. This advantage was almost entirely cited by providers who broker in surrogacy, where issues of parentage are most

¹⁰ According to Daisy Deomampo (PhD candidate in Anthropology), who is studying reproductive tourism in India, a new practice is emerging in that country in which intended parents bring their own donors with them from out of the country, or import frozen embryos (personal correspondence).

contested. If a woman is contracted to gestate and give birth to a child for someone else in exchange for a sum of money or out of the goodness of her heart, is she or is she not the legal mother of that child? There is no one legal answer to this question. Depending on what state or country the surrogate resides in, the answer varies. Yet providers cite “clarity” of this legal issue as an advantage of acquiring the services of a surrogate in the United States, with India once again as the foil.

Providers find the laws in the United States—as complex as they may be—ultimately clearer and more favorable than in other nations. This could be explained, however, by their built-in familiarity with United States law and ignorance of policies elsewhere. For example, Anne assumes incorrectly that India, like the United States, has birthright citizenship, and states, critically, that a child born in India to an Indian surrogate “is a citizen of India when it’s born.” (India eliminated birthright citizenship in 1987. As of 2004, Indian citizenship is only granted to those born in India if both parents are Indian citizens, or if one is a citizen and the other is not in the country illegally (Government of India 2003)). She goes on to say, speaking of Americans and others traveling to India for surrogates, “I don’t know what they’re all doing about getting the legal documents done, or the name put on the birth certificate that has their names legally. And these are things I know when couples call they go, ‘Oh you’re kidding! I never thought of *that*.’ They just don’t understand the complexity of what it takes to get a name on the birth certificate here.” While she acknowledges that securing parentage on birth certificates is a complex legal process, even in the United States, she speculates that it is even more so in other places.

Liam, CEO of a surrogacy agency, also sees surrogacy tourism to countries such as India as “risky.” Speaking of surrogacy in India or Russia, he states: “If everything goes smoothly and

you get out of the country, you're good. But, if the surrogate suddenly decided she was going to challenge it, you don't have any law that says she's not the mother." This is a risk, he says, that many are not willing to take. "I think, for some clients economically they don't have any choice but to take that risk. And that's understandable. But for clients who can afford to come to the United States, that would be their preference."

Although Anne and Liam speak of United States law being much less complex, when I interviewed family law attorneys, the process seemed quite overwhelming. When I sat down with Michael at his office in Los Angeles, I made him stop several times to explain to me the complex legal process involved with transnational surrogacy, which varies from state to state. In order to establish parentage in cases of surrogacy, special documents may be required, such as powers of attorney, advanced healthcare directives, and "guardianship documents that help protect the rights of the intended parents to make decisions for the child" even when that child is still in utero! In many states, attorneys also have to go through a court process, which "involves preparing court documents, filing them in court, going before a hearing, representing the parties in front of the court, and then getting a court order saying they are the legal parents, or whatever that state will allow." The process can be even more complicated when third party donors are involved, such as with surrogacy involving gay male couples. In those cases, some states automatically allow both men to be on the court order as legal parents, but in others, only the genetic parent is initially recognized, and the other parent must do a second parent adoption.

Even with all of this complexity, it still seems manageable to attorney Michael, especially for heterosexual married couples using their own genetic materials: "In a lot of states it's a pretty easy process. In all the states the process is *doable*, but in some states it's just simple, and you don't have to go court; the attorney can go for you." Furthermore, if the surrogacy occurs in

California or a handful of other states, the process is well established and the laws about parentage are clear.

Clarity of laws in the United States does not necessarily guarantee a smooth legal process, however. Deirdre, family law attorney in San Francisco Bay Area, told me a number of stories that made her reconsider whether it was worth the hassle of working with international clients. One couple that had contracted with a surrogate went through a divorce during the pregnancy, and decided they no longer wanted the child. Because they were in another country, she “couldn’t get [her] hands on them,” causing both Deirdre and the eight-month-pregnant surrogate to, reasonably, panic.

In another case, a couple went against her advice to bring their babies back to France with a United States passport and apply for French citizenship in a few years, and instead contacted the French consulate on their own. Because surrogacy is not legal in France, and the government “had indicated they would not give citizenship that was born of a surrogate without a full-on adoption ... the consulate decided they were going to make an example of this couple.” After France threatened to take the children away and put them in foster care, Deirdre had to involve the United States Department of State, since the children were American citizens:

So, we worked it out on a crappy compromise with the French government, that they would not take the children, but the family had to go through adoption, and abandonment, because they said “No, this birth mother has no rights to sign on anything. You can’t *do* it. You’re running afoul of international stuff.” So we finally worked it out, and the children were being placed with them—it was very screwy—in foster care, but with the same people, and they were going to have to do an adoption under French law. It all worked, but it was all very convoluted and should not have had to happen.¹¹

Although the above case is an example of an international couple going to great lengths to ensure the citizenship of their children in their home country, it also illustrates what for others

¹¹ Although it is unclear if this is the same case that Deirdre described, France recently denied citizenship to twin girls that had been born to a surrogate in California, after a ten-year battle by the parents to have them legally recognized (Associated Press 2011b).

may be construed as another advantage that the United States has to offer: birthright citizenship. That is, several of the providers in California who broker between intended parents and surrogate mothers cited the fact that if the child is born on United States soil—regardless of the circumstances of its birth or the status of any of the parties involved—that child is an American citizen. Granted, almost anyone who comes to the United States to acquire the services of a surrogate is already quite privileged. Surrogacy can cost upwards of \$100,000, requires time necessary to travel, and some savvy in navigating contracts and legal issues. According to some of my interview subjects, American citizenship is not a life or death issue, but would be an added benefit—more so than, say, if a child had birthright citizenship from a country such as India or Ukraine.¹²

Why choose a particular clinic?

Aside from the advantages of the United States, several providers indicated that their clients chose to work with them because of something their program, clinic, or agency *in particular* had to offer. Consumers are able to research and select from a wide variety of goods and services *regardless of geographic location*. Thus, an infertile heterosexual couple in France, for example, may not limit their search for a reproductive endocrinologist to their own country or even to Europe, but may expand their search to encompass the *global* fertility market, basing their selection on any number of criteria. The best clinic to suit their needs may be 25 miles away, or they just might be 2500 miles away. As Dr. B puts it:

We live in a global world. ... At the end, they're going to go where they think the doctor's great. They'll do what they have to do. ... I've had many patients come because I enjoy a good reputation. I got their friend pregnant, so their friend sent them to me. It

¹² See also this recent article about so-called “maternity tourism,” in which relatively privileged pregnant Chinese women travel to the United States to give birth (Medina 2011).

has nothing to do with regulations. It's just, you've got a medical problem, you want to see a doctor, let's go.

Information technology, communications, and air travel facilitate the growth and development of global markets, including the fertility industry.

The Internet has also contributed to the growth of global fertility markets. This is most obvious in the ability of intended parents to virtually shop globally for fertility services through Internet searches and by looking at the websites of clinics and programs. Almost every provider I spoke with told me that patients find them via the Internet, including Robin, who described the process to me as “someone’s looking for, you know, infertility support, or egg donor agencies, or surrogacy ... So if they type in those keywords, they find us.” Several other providers spoke in terms of precise keyword search terms and Google rankings. Liz mentioned how some sophisticated consumers will even “look up the statistics online. If they know a lot about what they’re doing, then they’ll look up pregnancy rates, and statistics, and they’ll go to the SART [Society for Assisted Reproductive Technology] website ... And there’s chat rooms, and there’s listservs, and all sorts of things like that.” Some clinics and programs tailor their Internet presence to an international market by enabling their sites to be translated into multiple languages, or by having special pages specifically targeting people who may be coming from abroad. This kind of marketing is especially important in countries where advertising by medical providers in television or print media is prohibited.

The advent of the Internet has also transformed the ways that physicians, clients, surrogates, lawyers, and other interested parties communicate transnationally. Many providers expressed appreciation for how email has made the process a lot easier for them, giving them time to answer questions at their leisure or after they conduct research, and how it circumvents the problems of bad phone connections, expensive phone bills for international calls, and

communicating with people who live in different time zones. Skype, too, has transformed the global fertility industry. Several of the providers I interviewed told me that some intended parents feel the need to be in close communication with the woman acting as their surrogate. In the past, this was especially hard for those who lived in other countries, or thousands of miles away, who couldn't travel to visit frequently with her throughout the pregnancy. With Skype, they are able to schedule weekly appointments, not only to see how she is doing and if she needs anything, but to actually *see* her belly and her body transform as their child grows within her. Anne told a vivid story of a surrogate who brought her laptop in with her to her ultrasound appointment so that the intended parents could be virtually present. "The doctor said 'No way!' And [the surrogate] said, 'No, no, no, they're in Russia! You know, it would mean the world.' And the doctor, seeing this couple on Skype, and she showed them the baby, could see how extraordinary this was." A virtual visit by way of Skype is not the same as being with the surrogate in person but, according to Anne, "It sure bridges a lot of gaps." Besides visits between surrogates and intended parents, Skype also enables video communications between physicians and patients, between egg donor agencies and egg donors, and a number of other social interactions, including various parts of the screening process for egg donors, surrogates, and intended parents.

Globalization has made the world a "tiny place," as Dr. B describes it:

I mean, everybody lives the same, everybody's got aspirations. A comfortable home. Food. So they're trying to have children. ... I'm dealing with a patient from Norway. She could be an American. She happens to be a physician. She's seeing me. If she didn't have an accent when she's talking to me, I could be talking to any American. Same humor, same interests, same questions. Everything exactly the same.

Globalization scholars may refer to this effect as a "leveling" or "flattening" of culture, in which people throughout the world begin to resemble each other in their dreams, habits, and even the

way they build families. Liam, CEO of a gay-focused fertility agency, sounds like he is channeling George Ritzer's (1996) McDonaldization thesis when he says that "I think that because the world really is more one now, it's not as different. You know, I travel all over the world myself, and I don't feel, unless I'm going to a Third World country, it's pretty much the same everywhere."

The "smallness" of the world means that intended parents may be more willing to travel across geographic borders to get their needs met. The globalization of the market only emphasizes the need for providers to distinguish themselves. Providers of fertility services compete not only on the basis of price, but on type and quality of service. Some see their services as so superior that they are beyond competition. As Dr. G told me, "There are [clinics] that ... cannot offer the quality that is being offered here, because the patients who come to us are in higher quality places in the first place, and they can't even get it there. You know? So it doesn't make sense to go to India for those. So this does not represent competition for us." Even more succinctly is an analogy he makes using Walmart and Bergdorf Goodman:

If you do things because you want to save money, it's one thing. If you do things because you're trying to get better quality, or because you're ... trying to get something that you cannot get elsewhere, it's something else. It's not that different than in any other sphere of the economy. If you go to Walmart, you do not expect to find the same items as you find in Bergdorf Goodman, for example. Yeah? Same thing here. And there are certain things that I think everybody can buy at Walmart and be perfectly happy, and there are others, which you either don't buy at Walmart, or you won't find at Walmart.

New York versus California

Besides competing with clinics and programs in other countries, clinics *within* the United States compete with one another. New York City, Los Angeles, and San Francisco are three of the largest centers of the fertility industry in the United States, and are draws for reproductive

tourists not only for the quantity and quality of clinics and programs, but for their status as international destinations. As global cities, they are already popular destinations for business and recreational travel, with infrastructure that includes major airports, hotels, restaurants, museums, and other tourist draws (Sassen 1999). Providers described the cities where they worked as “international destinations,” “destination spots” or “hubs” already known and familiar to an international audience. To accommodate his international patients, Dr. B and his staff provide them with lists of restaurants and Broadway shows. “They like to come to New York,” he says. “They just happen to be getting some good treatment here.” Jen, a genetic counselor, summed up the draw to New York City: “I mean, I just think New York is New York. Just being a huge place for technology and medicine. We have so many huge medical centers with great reputations. I think it’s just a place that people come for lots of things, not just medicine.” While New York may have Broadway, California, in turn, has its beaches. Dr. C describes how international patients’ knowledge about California translates into an expectation for high quality medical care:

It’s interesting, if you talk to somebody from Europe, from Eastern Europe, about the United States, and California. They all know California. They know the beach, and they know Sacramento, because they’ve been taught the state capitals. So they’ll come to a major city, Los Angeles, San Francisco, Sacramento, and expect that it’s a center of excellence.

One of the questions that I asked several respondents was why they thought the fertility industry has blossomed in New York City, Los Angeles, and San Francisco. Several pointed to their large populations and density as explanations for why these cities have an abundance of medical providers in general, and thus why they can support so many centers and practitioners of IVF and other high-technology fertility services. Dr. H described this as “regionalization in medicine,” wherein, “in order to run a good IVF program, you’ll probably need at least, as a

minimum, 60 cycles a year, and if you're in a very small population, there may not be the need for 60 cycles a year. So I think you're always going to see somewhat larger populations that will feed to a center." He was not the only provider to point out that New York City, Los Angeles, and San Francisco, besides having large populations, also have large numbers of wealthy people with expendable incomes. Given that fertility services, particularly the very expensive procedures such as IVF and ICSI, are often not covered by insurance, the fertility industry has tended to concentrate in wealthier cities. One physician, Dr. M, spoke of another demographic factor that may contribute to the growth of the fertility industry: she thought that it was possible that cities such as New York have a greater concentration of people who "dedicated most of their reproductive age into their career and profession," and therefore there was a greater need for assisted fertility services among this older demographic.

Consumers may decide between New York or California clinics and programs for a number of reasons. When I interviewed Shelby and Rebekah, we sat outside a café in the beautiful July sunshine of Southern California. Several times, they both pointed to the weather as a major appeal of California compared to New York. Thinking of the oppressive heat and humidity I knew was waiting for me back in my tiny New York apartment, I could not help but see their point. But could climate really lead an intended parent to choose one city over another, particularly if they would only be in town for a few weeks? Aside from the weather, Shelby and Rebekah claimed that another advantage that California has are cheaper costs for fertility services and a greater variety of egg donors to choose from.

Several respondents also described clinics and programs in New York and elsewhere on the East Coast as more culturally "conservative" than those in California, in terms of its laws and its medical care. They point to stricter laboratory regulations in New York State issued by the

Department of Health, a greater tendency to follow the rules, and more extensive testing procedures. The greatest difference in regulation, as outlined in Chapter 3, and thoroughly analyzed by Markens (2007), is that commercial surrogacy is not legal in New York State, whereas laws are quite favorable towards surrogacy in California. For intended parents wishing to contract with a surrogate, it makes much more sense to obtain all of the necessary services in California than in New York. Providers in New York can arrange for surrogates for their international clients, but there is much more legal wrangling and interstate traveling involved.

CONCLUSION

Providers offer more than high quality services and advanced technologies. They offer intangibles: a mystique of luxury, an aura of privilege and entitlement. Reproductive tourism is both a result and a determinant of “stratified reproduction” (Colen 1995). For those seeking fertility services, different classes of fertility markets have emerged, both within and between countries. To reiterate a point, the logic of the bottom line is *not* the sole determinant for reproductive tourism, particularly for the elite. This is not to say that *value* does not matter. Paying hundreds of thousands of dollars for a surrogate to carry your child may strike some as an extremely good value, worth every penny.

The United States has become a major destination for people throughout the world seeking assisted fertility services. Unlike destinations such as India and the Czech Republic, where surrogates may be contracted for a relatively cheap price, money is not the primary factor motivating reproductive tourists to travel to New York City, Los Angeles, and San Francisco. Through interviews with people who work in the fertility industry in these three major American

cities, I theorize three motives for reproductive tourism: the logic of the bottom line, the logic of personal autonomy, and the logic of global consumption.

Although the logic of the bottom line is not a major component of travel to the United States for fertility treatment, this motive is still paramount in any discussion of reproductive tourism. Given the high costs associated with assisted reproductive technologies, many individuals seek out cheaper locations to fulfill their demand for services. Rather than travel to New York City, Los Angeles, and San Francisco, those motivated by the logic of the bottom line would be more likely to travel to India, the Caribbean, or Eastern Europe.

My interview subjects cited the logic of personal autonomy as a more compelling reason for reproductive tourism. As American providers of assisted fertility services, they work in a country that is free of many of the regulatory hurdles and prohibitions found in nations such as Australia, Japan, the United Kingdom, and Italy. Those residing in countries where there are bans or severe restrictions on egg donation, surrogacy, and sex selection seek these services elsewhere, and find that the regulatory environment in the United States is much more open to these practices.

Yet, given that assisted fertility services are quite expensive, the logic of personal autonomy does not adequately explain why reproductive tourists do not automatically go to those countries that boast both a friendly regulatory environment *and* bargain prices. The logic of global consumption provides an explanation: reproductive tourists, particularly those from affluent backgrounds, view the fertility marketplace in global terms. They are savvy consumers, choosing particular clinics and doctors based not on bargain prices, but on other tangible and intangible factors, such as reputation, success rates, and quality of care. Further, they choose the United States in particular not only for its lax regulations, but for its high technology resources,

clarity of laws regarding parentage, and status as a global destination.

“Reproductive tourism” as a concept has already entered the public lexicon, but it has yet to be adequately theorized. By articulating these three “logics” motivating the practice, this chapter counterbalances the overemphasis on money as the primary variable, India as the primary destination, and surrogacy as the primary service. Despite the fact that assisted fertility services here are some of the most expensive in the world, the United States has emerged as a major destination for international reproductive tourists seeking egg donors, surrogates, and sex selection services from well-established and reputable providers.

Chapter Three

The “American” Character of the United States Fertility Industry

“The people reign in the American political world like God over the universe. It is the cause and aim of all things, everything comes from them and everything is absorbed in them.” – Alexis de Tocqueville (2003:271)

Since de Tocqueville, scholars and commentators have remarked on and debated the “exceptionalism” of the United States in such areas as geography, cultural values, demographics, political economy, governmental structure, public expenditures, military prowess, international influence, and social policy. Indeed, “American exceptionalism” is often a taken-for-granted concept in public discourse within the United States. For comparative scholars, the hypothetical exceptionalism of the United States poses an interesting area of inquiry. Using data collected by the OECD, for example, one can measure whether the United States is a statistical outlier when it comes to a particular policy or budgetary measure. Yet studying American exceptionalism can also be a tautological enterprise, in which one searches out those areas of American life where

the United States stands out like a sore thumb among its global neighbors, and then uses this as ipso facto proof of the very exceptionalism one set out to measure. Moreover, as Puar (2007) points out, the very naming of American exceptionalism often takes on an insidious double meaning, in that the ways in which the United States is seen as singular or unique often implies superiority.

In this chapter I aim to describe and analyze the “American” character of the United States fertility industry. Drawing on my own data in addition to secondary research, I argue that individual aspects of the United States fertility industry are not in themselves exceptional. However, the fertility industry has been shaped in a particular way that makes it stand out from fertility industries in other capitalist democracies. From a macro perspective, the American character of the fertility industry is a result of the combination of the following three factors: funding streams for research in infertility treatment and reproductive medicine; payment for fertility services; and the relative absence of regulation of assisted reproduction. What is significant about these three factors as they play out in the United States is the lack of national input (financial and regulatory), especially when compared to other countries. Moreover, it is the first two factors that have largely influenced the third. The net effect of private (rather than government) monies financing both research and clinical practice is a fundamentally less regulated industry. As will be articulated below, this is a field that is almost entirely *privatized* and *market-driven*, not only in its research funding and compensation for services, but in its regulation. It is this nexus of privatization, or neoliberalism, that offers a competitive advantage to clinics and providers in the United States reaching out to consumers in a global marketplace.

RESEARCH FUNDING

Although scientists in the United States, along with the United Kingdom and Australia, were early pioneers of reproductive technologies, in particular *in vitro fertilization* (IVF), American scientists significantly lacked the government support that their British and Australian counterparts received. In 1974, only a few months after the Supreme Court passed the landmark 1973 *Roe v. Wade* decision, the United States Congress instituted a “temporary” moratorium on the federal funding of fetal research (Boonstra 2001). Spar (2006) describes how “high-profile inquiries into the implications of IVF” in the United Kingdom, Australia, and the United States led to different conclusions (26). The United Kingdom legitimated IVF as a valid treatment for infertility and established a regulatory body called the Human Fertilisation and Embryology Authority (HFEA). Australia, likewise, validated IVF with regulatory bodies established in different states. In the United States, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in 1975 recommended that the ban on funding for fetal research be ended in order to support research in IVF; however, both anti-abortion fervor and political inertia kept the ban in place (Spar 2006:26-28; Boonstra 2001; Henig 2004). According to Boonstra (2001), the “de facto moratorium” on federal funding for IVF research persists even to today (3).

That private, rather than public, monies financed research in the United States is significant for a number of reasons. In her history of IVF, Robin Marantz Henig (2004) argues that bans on government monies for fetal and embryonic research (the underpinnings of IVF, stem-cell research, and a host of other applications) turned the field into a “cowboy science driven by supply and demand” (12). That is, because the U.S. government did not fund research, an opportunity was missed to *direct* the research, provide quality-control measures, and ultimately regulate practices that later grew out of this research. There were financial

consequences as well. The doctors who Spar (2006) describes as “victims of the ambiguous ban on federal funding,” ultimately became victors (28). “Quietly,” Spar writes, “doctors began to see the field of reproduction not only as a cutting edge of medicine but also as a distinctly profitable endeavor—expanding, unregulated, and catering to a population that seemed ever eager to pay” (29).

At least two of the providers I interviewed appeared to agree with Henig’s thesis about the path-dependent role that initial (and subsequent) lack of government financed research had on the direction of the field and existing practice today. Dr. C, a Bay Area physician in practice since the late 1980s, told me, “There’s really no established funding for doing research in this field. It’s all privately funded, all of it. And so programs like mine will start a clinical protocol, and establish it, without that big research network behind it.” This has implications for the development and promotion of particular technologies, and clinical practice more generally:

[As] technologies have matured in the laboratory, we’ve been able to bring those out into clinical practice very quickly. The problems that emerge along ... that pathway are that we have clinical needs that require use of technologies that are not clearly established. You know, you don’t have an elaborate ten-year safety record, and proof of efficacy and all that kind of stuff. Sometimes we have to adopt technologies before they’re proven, is what it comes down to. (Dr. C)

This history of the field was echoed by Dr. G, a New York doctor who first began practicing in Chicago in the early 1980s, when IVF was in its infancy. Lack of government research grants created an atmosphere ripe for technological innovation. Moreover, because this was such a new field with low success rates, patients also had low expectations, which pushed doctors to be daring and creative. According to Dr. G, “Since there’s so little to lose, and so much to gain, that experimentation, even if it is not well controlled, is warranted. And it was this trial and error that drove the field very quickly.” Unlike their counterparts in the United

Kingdom and Australia, who got government support for research coupled with government oversight, reproductive scientists and clinicians in the United States were researching and developing new protocols in privately funded clinics and medical schools, and largely absent of government interference.

The United States may have backed away from funding early research in reproductive medicine, but this is not necessarily reflective of American attitudes towards using public monies for science and medical research. Rather, research involving reproductive materials is a particular *type* of science that government has been loath to finance, with all of its implications about “playing God,” tinkering with life, and the dredging up of long-entrenched cultural schisms regarding abortion. Dr. C referred to reproduction as a “political hot potato,” elaborating that “People don’t want to think about it, on a public basis. The President doesn’t want to talk about reproduction. Congress doesn’t want to think about reproduction.”

Ironically, as Cooper (2008) points out, federal money began to pour into the life sciences in the 1980s, making it “the most heavily funded area of basic science research in the United States, apart from defense” (27). Overall, scientific and medical research in the United States is actually quite well funded when compared to other nations. According to data from the OECD, the United States’ gross domestic expenditure (including both public and private financing) on research and development as a percentage of GDP is well above average (OECD 2010:151), in part due to the significant amount of money (about 57% of R & D financing) geared towards defense (OECD 2009:74). Moreover, the United States provides a greater amount of public support for health-related R & D than any other OECD nation, about .22% of this country’s total GDP (OECD 2009:59). Whereas fetal and embryonic research remained in the private sphere, other scientific research (including in the biological sciences) developed in the context of

alliances between public and private entities, leading to the creation of the biotech and pharmaceutical industries (Cooper 2008). Thus, although Henig (2004), Spar (2006), and practitioners in the field conclude that lack of government funding was ultimately a boon to the highly lucrative fertility industry, Cooper's research implies that even if the moratorium on fetal research funding had been lifted, infertility treatment would still have become a capitalist enterprise (see also Waldby and Mitchell 2006).

That the United States has not financed embryonic research does not mean that the government did not take any interest in the field. It was ethical and political motivations that ultimately led to de jure and de facto bans on government financing of research involving human reproductive materials. Under the Bush administration, bans on funding for stem cell research had clear echoes of the bans faced by reproductive scientists in earlier decades. Ironically, bans on federal funding do not necessarily quell research in the field. In the case of IVF and other assisted reproductive technologies, bans on funding merely shifted the research beyond the purview of government. By not financing research, the government, to a certain extent, voided their influence over the direction of research and clinical practice. One can also read the financing of research in the field of reproductive medicine in political economic terms (Cooper 2008). That is, the absence of government funding and oversight, and the subsequent domination by industry and market forces, signals the privatization of reproductive medicine.

REIMBURSEMENT FOR ASSISTED FERTILITY SERVICES

A second factor in which the United States fertility industry differs from virtually every other country is in payment or reimbursement for assisted fertility services. According to a comparative study of several nations with prominent fertility industries, the national

governments in the United Kingdom, Scandinavian countries (Denmark, Sweden, Norway, Finland, and Iceland), Japan, and Australia all reimburse for some fertility treatments (G. M. Chambers et al. 2009:2286). In Canada, the province of Ontario reimburses for fertility treatments, but this is not the case in the rest of the federation (ibid). Of the 57 nations surveyed by the IFFS [International Federation of Fertility Societies], about half do not have any “third party reimbursement” for assisted reproductive technology services, and 25 have complete or partial coverage by a national health plan (Jones et al. 2007:S14-S16). In this surveillance report, the United States is a clear outlier, in that this country “appears to be the only nation in which the only insurance available is through private sources” (Jones et al. 2007:S14).

The United States government (both federal and state-level) does not directly reimburse for assisted fertility services or medications, although people with government-issued health insurance may have some services and medications covered under their particular programs¹³. For the most part, however, payment for assisted fertility services (to medical providers, clinics, gamete donors, surrogates, pharmaceutical companies, and so on) is privatized; payment is either provided by health insurance and managed care corporations, out-of-pocket by individuals utilizing services, or a combination of the two. This is, of course, not unique to the field of reproductive medicine, but is an aspect of health care provision and payment in the United States more generally (Hacker 2002; Quadagno 2004). Approximately 50 million Americans currently lack access to health insurance coverage (Kaiser Commission on Medicaid and the Uninsured 2010). Even if the Affordable Care Act (ACA) goes into full effect in 2014, millions will still lack adequate access to health care coverage. The financing of the American fertility industry is

¹³ Women veterans, for example, may receive limited infertility diagnosis and treatment (U.S. Department of Veterans Affairs 2009 <http://www.va.gov/healtheligibility/coveredservices/SpecialBenefits.asp>).

in part a legacy of one of the primary examples of American exceptionalism: our lack of a national health care system (Hacker 2002; Quadagno 2004).

Fourteen states currently have legislation mandating that insurance companies cover or offer some infertility treatment (see Table 3.1, Column 1). Although these include the three most heavily populated states of California, New York, and Texas, millions of Americans reside in states where insurance coverage for fertility services is not mandated. Furthermore, even in those states that require that insurance companies cover treatment, the services may only cover diagnosis and inexpensive procedures, or may outright exclude IVF, which is one of the most costly reproductive technologies. Of the fourteen mandated states, only eight specify coverage for IVF (see Table 1, Column 2). Most individuals in the United States, even those with health care insurance, must pay out of pocket for fertility treatment.

Table 3.1 Insurance Mandates

States with Insurance Mandate	Include coverage for IVF
Arkansas	X
California	
Connecticut	X
Hawaii	X
Illinois	X
Maryland	X
Massachusetts	X
Montana	
New Jersey	X
New York	
Ohio	
Rhode Island	X
Texas	
West Virginia	

Source: National Conference of State Legislatures, *State Laws Related to Insurance Coverage for Infertility Treatment*, 2010

There are at least three consequences of the private compensation model in the United States: (1) *Relative cost of assisted fertility services*. Costs may be higher since service providers are largely dealing with individual consumers and private insurance companies rather than one central agency who can negotiate prices. This is similar to arguments made about lowering the costs of prescription drugs by government negotiating directly with pharmaceutical corporations (Frakt, Pizer, and Hendricks 2008). (2) *Stratification of users of assisted fertility services and mismatch of supply and demand*. Most individuals in the United States who would like assisted fertility services cannot actually afford them. This results in reproductive tourism to countries where services are cheaper. Finally, (3) *Implications of privatization on regulation*. Besides lacking negotiation power over the costs of services, technologies, and medications, the government also lacks power as a regulatory arm. By not paying for either research *or* the use of services, the government essentially loses the power of the purse-string. Fertility treatment and assisted reproduction are left in private hands.

1. Relative cost of assisted fertility services

In regard to insurance coverage for fertility treatment affecting its relative cost, the fertility industry professionals I interviewed pointed to legislation in other localities (states, countries, and/or global regions) that they believed resulted in consumers having to pay less for services there. For example, Robin, the director of a Los Angeles-based egg donation program, sees Massachusetts (a state that mandates IVF coverage) as a model for California to follow. She states:

Because right now, most people in California don't get it paid for at all. Zero. ... So I believe that the more that we can get that paid for, the better. And, that will make it accessible to a broader range of people. Right now the costs of the medical piece are so

high that—and a lot of that is pharmaceuticals—the cost is so high it just automatically excludes a whole lot of people.

Mandated insurance coverage of IVF in California would not necessarily bring down the *price* of IVF treatment, but having some or all of it covered by health insurance would at least reduce the out-of-pocket expenses for some consumers. Depending on how legislation were written, mandated coverage could expand the number of people who will have access to treatment—and thus expand the market for fertility services in California and other states. Consumers benefit by having greater access, and fertility services providers benefit by gaining more clients.

Researchers have found several consequences related to mandated insurance coverage. Henne and Bundorf (2008) find that there is greater increase in use of assisted reproductive technologies in states that have adopted mandated insurance coverage for infertility treatment. Additionally, mandated states have lower rates of high-risk multiple pregnancies and births, particularly in those states that have what the above authors describe as “comprehensive” insurance coverage. Using more updated data, J. R. Martin et al. (2011) similarly find that providers in states without mandated insurance coverage for IVF transfer more embryos than those in mandated states, resulting in higher pregnancy, live-birth, and multiple pregnancy rates.

In addition to state-to-state comparisons, providers I spoke with compared the United States as a whole with other nations that have more “socialized medicine” (a term that came up frequently in my interviews), arguing that costs are cheaper in countries with more financial support. According to Dr. C, because European countries with comprehensive health care coverage have lower costs for treatment, this results in more overall treatment cycles happening in Europe than in the United States. Further, he and others I spoke with provide anecdotal evidence for claims about the relationship between insurance coverage and multiple pregnancies (Henne and Bundorf 2008; J. R. Martin et al. 2011). Michael (attorney) argued that when

patients have to pay for IVF cycles out of pocket (which can run at least \$12,000 per cycle)¹⁴, there is a greater incentive on the part of the patient to push for more medically risky procedures, such as multiple embryo transfers:

You're like, you know, 'I'll be damned if I'm going to risk it and then wait and send some embryos for later. Let's do three. Let's transfer three and we'll hope that we'll get one, or two.' So there's this sort of motivation because of the insurance and the cost, to go for it.

Indeed, Chambers et al. (2009) find that of the six countries/regions they studied, the United States, which was the only country without any federal or state funding of assisted reproductive technologies, had the highest multiple birth rate. It also had the highest cost (\$12,513) for an IVF cycle, compared to \$8500 in Canada, \$5645 in Australia, \$5549 in Scandinavia, and the lowest costs in Japan at \$3956 per cycle (G. M. Chambers et al. 2009:2288).

2. Stratification of users of reproductive technologies

In her remarkable essay about West Indian nannies, Shellee Colen (1995) introduced the phrase “stratified reproduction” to delineate how women of different social locations—based on race, socioeconomic status, nationality, and immigration status—have stratified reproductive options, circumstances, and livelihoods. Although Colen wrote primarily about caretaking and childrearing, Ginsburg and Rapp (1995) have extended the term to other aspects of reproduction, including conception, pregnancy, and childbirth. Use of reproductive technologies is also highly stratified, and the privatization of the industry makes it even more so. Because most Americans do not currently have access to insurance that covers all aspects of fertility treatment (even those in mandated states such as Massachusetts and New York), use of reproductive technologies is

¹⁴ The average cost of an IVF cycle in the United States is estimated to be \$12,513 in 2006 dollars (G. M. Chambers et al. 2009). A recent qualitative study finds that of the cohort of 398 women pursuing fertility treatment who they surveyed, median costs for IVF treatment was \$24,373 (Katz et al. 2011).

highly stratified. An estimated 85% of IVF consumers in the United States pay for fertility treatment out of pocket (Katz et al. 2011).

Anecdotally, most of the providers I interviewed acknowledged that their clients—both domestic and international—were a relatively privileged group. A question on my interview protocol that I asked every provider was to estimate the income range of their typical clients, from high-income (above \$100,000 per year), to middle-income (between \$30,000 and \$100,000 per year), to low-income (under \$30,000 per year). A few hedged that they knew nothing about their clients' finances. For example, Michael, a Los Angeles family law attorney, gave a very vague, lawyerly answer, circling around the fact that the majority of his clients are probably well off:

We never really ask them what their income levels are. I could make an assumption, that because they have the finances to afford the process, they're probably not low-income. They may not even be middle-income ... [They] can find the resources, whether it's through home equity lines of credit, or whatever else. They may have family helping them out. So I'd say at least middle-income and higher-income, generally speaking.

Tammy, a Bay Area social worker gave a similarly evasive answer about her clients' income, preferring to call them middle-and upper-middle-class rather than wealthy. She also provided a broader, more nuanced demographic description of her typical clients:

They have earning power. They tend to be professionals. They tend to have enough earning potential where they can eventually pull themselves out of debt. They have supportive families, or they borrow from their home, or their family members.

Others were wary of describing a "typical" client, and replied that their clients' incomes were highly variable. Most providers I spoke with, however, were quite blunt about the fact their clients are high earners. In fact, many recognized that one would *require* a high income in order to access their services. For example, Liz, coordinator of an egg donation program in New York City, estimated that the majority of her patients are high income, particularly because at her

clinic, patients tend to go through several cycles of IVF using their own ova before turning to egg donation. Costs quickly add up, draining financial resources. By the time they see her for egg donor services, they “have already spent fifty, sixty, seventy thousand doing IVF.”

Ironically, she says, “By the time they finish all of their IVF and come to donor egg, I don’t think they’re as wealthy as when they started off, you know?” According to a recent qualitative study, the median cost of IVF using donated eggs was approximately \$14,000 more than IVF alone (Katz et al. 2011).

Robin is even more straightforward about the fact that all of her clients make over \$100,000. “Yes, absolutely,” she says. “They can’t afford it otherwise.” Shelby and Rebekah, co-owners of a surrogacy agency, also in Los Angeles, went back and forth with each other about how wealthy one needs to be to acquire various services, with surrogacy being the most costly of all expenses:

Shelby: It’s not cheap, and it’s not getting cheaper. So, it would be great if, you know, everybody could afford it, but it’s just not the case. ... Infertility affects everybody. Unfortunately, only—

Rebekah: Only a slice can get services.

Shelby: ... Egg donation, a bigger bracket. IVF, an even bigger bracket. But surrogacy is just... We get these calls all the time. You know, “Can I do it for \$30,000?” It’s like, no, unless you have a sister willing to do it.

Rebekah: And frozen embryos. The pregnancy itself costs.

Shelby: Yeah! Forget us! Even if you do it on your own ... you should have a contract, you should do psych, you need the medications, you need the IVF, you need the monitoring for your sister or friend.

Rebekah: With an agency, you have to figure for non-international clients, it’s \$80- to \$100,000. ...

Besides class stratification is *regional* stratification. If one looks at the list of fertility clinics that report statistics to the CDC, one can see that clinics are not evenly located in all

states. Whereas Montana, Wyoming, and Maine have zero fertility clinics, California, New York, Texas, Illinois, and Florida each have over twenty [see Table 3.2] (CDC, ASRM, and SART 2010). The fertility industry is also concentrated *within* those states, with the largest numbers of clinics concentrated in Southern California, New York City, the San Francisco Bay Area, Chicago, Houston, and Dallas/Fort Worth (in Florida, clinics are spread throughout the state). Egg donor and surrogacy programs are also concentrated in a handful of states. On the published list of ASRM-approved egg donor agencies, 31 out of 79 agencies are located in California (American Society for Reproductive Medicine (ASRM) 2011).

Dr. H, a Bay Area physician I interviewed, believes that the industry has concentrated in these areas as a direct result of the high cost of fertility treatment. Because these expensive procedures tend not to be covered by insurance, clinics and agencies have opened in cities that have large populations and high numbers of people with expendable incomes. Of the five states with the highest concentration of fertility clinics, only Illinois mandates that insurers cover IVF. California and New York mandates some coverage for infertility diagnosis and treatment, but excludes IVF. Texas mandates that insurers offer IVF and other treatments, but does mandate coverage. Florida currently has no legislation regarding mandated insurance coverage for infertility diagnosis and treatment (National Conference of State Legislatures 2010).

Table 3.2 Concentration and number of fertility clinics in United States (including D.C. and Puerto Rico)

Zero clinics	1-5 clinics	5-10 clinics	11-20 clinics	21-30 clinics	Over 30 clinics
Maine	Alaska (1)	Alabama (6)	Arizona (10)	Illinois (27)	California (59)
Montana	Arkansas (1)	Colorado (7)	Michigan (14)	Florida (29)	New York (35)
Wyoming	Delaware (2)	Connecticut (7)	N. Carolina(10)	New Jersey (21)	Texas (35)
	District of Col. (4)	Georgia (9)	Ohio (12)		
	Idaho (1)	Hawaii (5)	Pennsylvania (19)		
	Iowa (2)	Indiana (9)	Virginia (13)		
	Kentucky (3)	Kansas (5)	Washington (10)		
	Mississippi (2)	Louisiana (5)			
	Nebraska (4)	Maryland (6)			
	Nevada (3)	Mass. (8)			
	New Hampshire (1)	Minnesota (5)			
	New Mexico (1)	Missouri (8)			

North Dakota (1)	Tennessee (7)
Oklahoma (3)	Wisconsin (9)
Oregon (4)	
Puerto Rico (2)	
Rhode Island (1)	
South Carolina (4)	
South Dakota (1)	
Utah (2)	
Vermont (1)	
West Virginia (3)	

Source: Centers for Disease Control and Prevention (CDC), *2008 Assisted Reproductive Technology Report*

Besides class and regional stratification, consumers of assisted reproductive technologies are also stratified by race, ethnicity, and sexual orientation. Although all of the providers I interviewed described their clients as coming from diverse backgrounds, more than half of them acknowledged that the majority of their patients are white, with Asians and Asian Americans being the next most typical category. Providers at two clinics, one in Los Angeles, the other in San Francisco, are outliers in that they specifically target Asian and Asian American populations, who make up the bulk of their clientele. Similarly, while most providers told me that their clients are typically married heterosexual couples, they also report see increasing number of gay clients, particularly gay men. And, similar to the two clinics that have a majority of Asian clients, two organizations in Los Angeles, one a law firm and the other a surrogacy agency, have gay men making up the majority of their clients.

This anecdotal data should not be generalized to the American fertility industry at large, given my small sample size, the fact that I limited my sample to providers who work with clients from abroad, and that even the providers who gave me specific percentages were largely making estimates off the top of their heads. A number of providers pointed to the fact that their large numbers of international clients (as many as 60%) make for an extremely diverse client base, in all senses of the word. By looking at secondary data, however, patterns of racial stratification do emerge. Although higher percentages of Hispanic and African American women report infertility than do white women, they are less likely to access treatment (Jain 2006; Missmer, Seifer, and

Jain 2011). Asian American, Black, and Hispanic women also have worse outcomes than white women who use fertility treatment, including decreased odds of achieving pregnancy and live birth (Fujimoto et al. 2010). Lesbians and gay men also face barriers to treatment. Johnson (2009), for example, finds that some fertility clinics still actively or implicitly exclude lesbians and/or unmarried women from receiving services (see also Mamo 2007).

In addition to greater use of assistive technologies and lower rates of multiple pregnancies, there may also be a relationship between insurance mandates and the number of providers in a given region. Centers for assisted reproductive technologies are more plentiful in states with mandated insurance coverage for fertility services (Nangia, Likosky, and Wang 2010). As Table 3.2 indicated, depending on what state or part of the country one is located in, one will have more or less access to fertility clinics and services. People in fertility clinic deserts will have to travel long distances to access treatment.

Related to stratification of clients, high costs and lack of insurance coverage mean that all those who request or desire assisted fertility services cannot access it. According to Chambers et. al. (2009), “only 24% of demand for ART treatment cycles in North America was met in 2003” (2288). Dr. O, Bay Area physician, put it in stark terms: “The only reason [patients] can’t do it is because they can’t pay for it. That’s pretty sad.” Other providers described scenarios in which insurance companies claim on paper that they cover fertility services, but in reality, the caps restrict both the quality and quantity of treatments. Sometimes insurance companies will cover diagnosis of infertility, but will not cover its treatment.

3. Implications of privatization on regulation

In a later section I will discuss more precisely the structure of regulation of assisted fertility in the United States. Here I would like to draw upon my interview data for providers' perspectives on how the financing of assisted fertility services impacts the nature of regulation of this industry. Dr. G, for example, believes that ideally, physicians—with some input from their patients—should have the greatest voice in determining just how regulated the fertility industry should be. Input from “the payers,” as he put it, almost comes as an afterthought.

I think the payer's entitled to have an opinion, you know, whoever that payer is. But I think in the final analysis, it should be the physician who has the greatest input.

Yet Dr. G recognizes that this is only an ideal, and that globally, the payer—whether that is insurance companies or government—exerts power over the organization and practice of reproductive medicine. To back up this claim, he compares the private insurance-driven system in the United States with the more socialized systems in Europe:

I think our European colleagues are coming from a different administrative governing philosophy than we do. Many of these countries come from socialized medical systems, or work in socialized medical systems where the government is the principal payer for services. And that, of course, changes the dynamics of who decides what should be done and shouldn't be done.

Since the United States government is not the payer, lawmakers have less reason—or right—to make rules about infertility treatment and assisted fertility services. Access filters down to what insurance companies are willing to pay for, and beyond that, what individual consumers can afford to pay for on their own.

Dr. O, in California, appears to concur with this idea of Dr. G's. He describes the fertility industry in California as largely a “cash business.” Since most of his patients pay out of pocket, “There's no reason for anybody to regulate it.” Later, when I asked him to compare the American fertility industry with that of other nations, his words echo Dr. G's comparison of European socialism with American individualism:

We have much less regulation compared to everywhere else. Because everywhere else, there is government payment involved, and along with that comes government regulation.

Thus, although many providers I spoke with lamented the fact that the current system was so stratified that the majority of people who want assisted fertility services cannot afford them or do not have insurance that will cover treatment, this system does work in their favor. As a largely “cash business,” providers can avoid government regulation *and* the bureaucracy of insurance companies. This harkens back to the “golden age of doctoring,” in which physicians were largely self-employed businessmen who operated on a fee-for-service basis, beyond the control of both government and managed care (McKinlay and Marceau 2009).

Yet even though Dr. O and others spoke of the lack of regulation as a consequence of the cash business nature of the fertility industry, they were also quick to describe how the insurance industry, rather than the government, sometimes fills in the role of determining the nature of services that physicians are able to offer. One physician provided the example of an insurance company that mandated that before covering any IVF cycles, couples must try a particular number of insemination cycles (a much less expensive treatment), even if the physician determines that IVF is a more appropriate treatment.

All of my interviews were conducted in the summer that health care reform was being debated by the United States Congress, and details of the Affordable Care Act had yet to be decided. I asked the providers to put on their fortune-telling lenses and speculate about how this would affect coverage for infertility treatment. A physician I interviewed in Los Angeles was cynical about how health care reform would affect infertility treatment. He used New Jersey, which is a mandated state, as an example of a negative outcome of insurance coverage:

New Jersey covers infertility. Huge, huge numbers, okay? The poor doctors are working for next to nothing. And so what it's done is disheartened everyone. I've got an embryologist working for me from New Jersey who says, “Listen, it's a *mill*.”

From his perspective, mandated insurance coverage has made quality of care in New Jersey decrease. If national health care reform mandated insurance coverage, he does not see the situation improving any.

I think that they'll probably put some things in there about infertility being covered, and it'll immediately be followed by limitations on that coverage. It'll be the same as everywhere else. ... Like here, the Screen Actors guild ... [covers] infertility, [but with] a thousand dollar maximum. Well, you know, that's like not even the first visit. Yeah, it's covered, but it's not covered. I could see that coming in a national plan.

Besides mandated coverage for IVF and other fertility treatment, providers also offered conflicting answers regarding their views on movement towards universal or single-payer style systems. Dr. G worried about long waits under "socialized medicine," arguing that it can reduce quality of care. He gives the example of a 39-year-old woman who has to wait a year for an IVF cycle, and becomes 25% less likely of achieving a pregnancy because she is one year older. "No other area in medicine," says Dr. G, "projects the difference as clearly as IVF."

Robin had a nuanced response, seeing positives and negatives. While she would be happy that "more people will have access, then more people will have babies," she does not want to see a system that prevents people from using their own money to purchase health care. Nor would she want to see a government program like Medicare that does not adequately compensate physicians. That scenario would be "disastrous," causing the few good fertility doctors that are out there to leave the field.

Others were not as pessimistic. Linda, for example, operations director of a Los Angeles clinic, thinks health care reform could level the playing field between "ethical" doctors who "don't charge an arm and a leg" and wealthy doctors. Several providers also made "wish lists" for things they would like to see covered by insurance where gaps currently exist, including coverage for pregnancy, surrogacy, egg donation, and newborn babies born to international

clients. According to Shelby, she and her partner Rebekah require international intended parents to acquire insurance for their newborns (which, they say, can cost around \$30,000 per policy), because if the newborn requires intensive care, the surrogate, as the birth mother, may find herself billed for medical expenses.

Because, what happens is a lot of people did end up having ... triplets or high multiples, and those are the ones that end up with multi-million dollar bills in the NICU [neonatal intensive care unit]. ... That's our biggest problem. That's going to be what kills surrogacy eventually. And that will be why people go from America to other countries.

EXCEPTIONALISM IN PUBLIC POLICY

The above discussion pointed to some of the areas where the United States fertility industry differs from the practice of reproductive medicine and assisted fertility in other countries. Although regulation was touched upon, this area deserves more elaboration, for it is within the realm of public policy that the United States most stands out. It is my contention, moreover, that it is precisely the status of public policies concerning reproductive technologies that in large part drives the practice of reproductive tourism to the United States. While the above discussion may have shed some light upon how unique (if at all) the United States is in its practice, it cannot account for the dynamic of hundreds, if not thousands, of international clients traveling across borders in order to receive services in this country. Indeed, the very expense of services in the United States, and the lack of social support for reimbursement, would assume that the direction of reproductive tourism is primarily in the opposite direction from the one on which this dissertation focuses: Americans who cannot afford desired services and technologies in this country may very likely travel to cheaper locales to secure the same (or similar) services and technologies. Yet why would a non-American citizen travel here, when the costs are arguably much higher? While several of the providers pointed to the *quality* of services (a point

to which I shall return), it is worth noting how the landscape of public policy in the United States largely differs among many other nations. It is not exceptional in its lack of federal or national policy, but it is the *combination* of high quality services and lax public policy that, I argue, largely drives reproductive tourism to New York City, Los Angeles, and San Francisco.

When I attended a fertility and adoption conference in New York City in 2006, I watched a debate between a prominent reproductive endocrinologist and a bioethicist about the ethics of paying young women for their eggs for IVF or stem cell research. Aside from the lively debate about consent and coercion, one of the most interesting comments I took note of was made by the physician, who stated something to the effect of, “People think that the fertility industry is not regulated. That is untrue. We are one of *the* most regulated fields of medicine.” My ears perked up at this statement because the idea that reproductive medicine in the United States is highly regulated was in great contrast to articles I had been reading that described this country as the “wild West” of infertility (e.g. Hecht 2001). It was my impression that the United States is one of the *least* regulated countries in the matter of assisted fertility services.

Yet the physician was not comparing reproductive medicine in the United States to reproductive medicine in other countries. Rather, he was comparing the regulation of reproductive medicine to the regulation of other medical fields. This is an important distinction. Before addressing how the providers I interviewed saw their field from both angles—as compared to other countries, as well as in comparison with other medical fields—it is first necessary to outline what the existing public policies in the United States are.

Federal Policies

Contrary to the notion that the United States is absent any national regulation regarding assisted fertility and third party reproduction, there are at least three federal policies applicable to reproductive medicine. Chronologically, these three policies include the Clinical Laboratory Improvement Amendments (CLIA), established by Congress in 1988, the 1992 Fertility Clinic Success Rate and Certification Act, and the 2005 FDA guidelines entitled Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products.

CLIA is administered by the FDA and the Centers for Medicare & Medicaid Services (CMS), and sets national standards for laboratories that test human specimens (FDA 2009). CLIA affects providers such as fertility clinics with on-site laboratories. It also affects those providers who outsource testing and lab work, such as egg donor and surrogacy programs. Although from my vantage point, CLIA sounds relatively benign, some of the providers I spoke with portrayed the FDA and other regulators as fearsome tools of surveillance in their programs. Linda, for example, says “The FDA doesn’t tell anybody when they’re going to come. But it’s really hard, because since 2005, they’ve been training inspectors, and you just never know when they’re going to walk through your doors, when they’re going to come out.” Moreover, the line between “suggested” and “mandated” standards is blurred, according to Linda:

Some of the laboratory testing, what they do is they ... aren’t telling you [that] you have to do it, but they’re recommending you *should* do it, so you better do it. Because if you get inspected and you’re not doing it, even if they didn’t tell you [that] you have to do it, you’re still going to get cited.

However burdensome CLIA is, it is not *unique* to reproductive medicine, but affects all sorts of medical fields.

The 1992 Fertility Clinic Success Rate and Certification Act, however, is specific to this field. It was issued by the Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC), and developed in consultation with professional

organizations including the American Society for Reproductive Medicine (ASRM), the Society for Assisted Reproductive Technology (SART), the College of American Pathologists (CAP), and the American Association of Bioanalysts, as well as the infertility advocacy group RESOLVE (CDC 1998). According to its description in the *Federal Register*, it “was intended to provide the public with comparable information concerning the effectiveness of infertility services and to assure the quality of such services by providing for the certification of embryo laboratories” (CDC 1998:60178). In addition to establishing standards for laboratories that handle embryos, this Act requires collection of data from fertility clinics regarding pregnancy rates, to be compiled and published by the CDC in annual reports. Consumers can then view these statistics (by individual clinic or in aggregate) on the CDC website in order to help them choose a clinic they wish to work with.

As I describe in Chapter 4, there have been some unintended consequences of this Act, including a possible rise in high risk multiple pregnancies by clinics wishing to improve their now publicly available pregnancy success rates. Some providers also complain that these regulations mandating statistics reporting and laboratory standards are overly onerous. According to Dr. C, his clinic was already reporting statistics prior to this Act. “And honestly,” he said to me, “they just made the process a lot more complicated without making it any better when they passed this law.”

The national policy that providers were most upset by was issued in 2005, when the FDA and the United States Department of Health and Human Services (HHS) issued guidelines regarding tissue donation. The “Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products” is aimed at industry members as a means to assist them in determining the eligibility of prospective donors of cells and tissues, including sperm, eggs,

and embryos, to prevent the transmission of communicable diseases. The guidelines require that establishments dealing in the donation of human tissues and cells test, screen, and determine donor eligibility, keep and maintain records of test results and interpretations, quarantine cellular materials while they are being tested, and use the FDA's extensive list of risk factors and conditions, as well as clinical and physical evidence (FDA 2007).

Significantly, the guidelines exclude entire classes of people from donating cells and tissues because they are deemed to be "at risk" for communicable diseases because of their medical history, social position, and/or their *behavior*. This long list of excluded classes includes: men who have had sex with other men, intravenous drug users, sex workers, people who have been imprisoned, and people who have been exposed to a wide variety of diseases, including HIV, hepatitis, and syphilis. Also excluded are people who lived abroad in Europe during specific time periods, or who were born or lived in certain African countries (FDA 2007).

This quite extensive list of donors who should be considered ineligible presents a constant source of irritation and frustration to many of the providers I interviewed. Although they understand the risks of disease transmission involved in tissue transfer, many argue that these risks apply more to blood transfusions and organ donation, and not to reproductive medicine. Had the FDA consulted with practitioners of reproductive medicine, I was repeatedly told, those practitioners would have explained that the same risks do not apply universally to all sorts of tissue transfer. For example, Robin complained that the FDA regulations make "no sense" when it comes to egg donation. When I asked her to elaborate, she told me:

We are not able to accept any donors that have been to Europe, or England, during the Mad Cow time. ... Basically, any bright college student who's around 25 and did a semester abroad is pretty much screwed. And so that really reduces ... our egg donor pool, and I think it's unfortunate, because I'm told there isn't a single instance anywhere of eggs being infected by Mad Cow. There is no medical science behind it.

Linda, similarly, is frustrated by the ways in which overly rigid FDA regulations exclude donors:

Some of the laboratory testing that's required for third-party cycles ... don't make sense for certain ethnic groups. Meaning, they are going to come out positive. But it's not going to, in the doctor's knowledge ... jeopardize the pregnancy, harm a fetus, nothing like that. But, as far as the FDA goes, the way they're reading it is, it could. So, you might end up with positive results, and have to disqualify a perfectly good donor candidate ... for no medical, real reason. But, the FDA has put down this rule and regulation, and you better follow it, because they're going to come and you're not going to know what charts they're going to want to see.

Liam, CEO of a surrogacy agency that works primarily with gay men, also argued that some of the FDA eligibility guidelines "weren't medically sound as they applied to sperm donation and egg donation. And so, it actually created an impact that is excluding certain donors that before, could have donated, but now are not allowed to," including gay men and people who had lived abroad. Like Robin, he sees that a policy developed "to protect the health and well-being of society" is being applied too broadly.

Interestingly, the egg donor coordinator of a program at a large fertility clinic in New York City explained to me that despite these FDA guidelines, there are ways to get around them.

Liz: I like [the guidelines]. It brings a sense of reassurance.

Lauren: How so?

Liz: Just, you really feel like you're doing the right thing. You know? Not cutting corners. Not compromising.

Lauren: Do you ever feel that it gets in the way of doing things that you would like to do? Or how you'd like the program to grow?

Liz: No, I don't think it gets in the way. I mean, I know that there have been patients that have felt that. An example is, if the patient presents with ... a known donor, and she's a carrier of an infectious disease, they want to proceed anyways. We can do it, and we did do it, and we have to get exceptions from regulations, from the DOH [Department of Health] to do it. FDA—doesn't matter (*laughs*). I don't know if you knew that or not. Doesn't matter if it's a known donation situation, and one is a carrier of another, as long as the physician is informed, that's all you need to do with the FDA.

Although guidelines were created as national standards, Liz's experience with the FDA leads her to see them as somewhat flexible. Many of the other providers, however, make the opposite conclusion.

U.S. Supreme Court decisions

Besides federal regulations and congressional legislation, the other area of policy that affects the fertility industry on a national level is Supreme Court decisions. There are no specific decisions that explicitly deal with assisted fertility, surrogacy, or genetic testing, but there are at least four decisions that have implications for this field: *Skinner v. Oklahoma*, *Griswold v. Connecticut*, *Eisenstadt v. Baird*, and *Roe v. Wade*. Scholars of reproductive rights point to all four as landmark decisions that impinge upon issues of reproductive autonomy and bodily integrity, establishing rights to procreate, to contraception, and to terminate pregnancy, respectively.

In the 1942 case of *Skinner v. Oklahoma*, the Supreme Court struck down that state's punitive compulsory sterilization laws, establishing the "right to have offspring" as a Constitutional and indeed human right (316 U.S. 535). *Griswold v. Connecticut*, decided in 1965, reversed prohibitions against contraception for married people (381 U.S. 479). Five years later, the Supreme Court decision in *Eisenstadt v. Baird* extended the right to contraception to unmarried people, arguing that to do otherwise would discriminate against the unmarried (405 U.S. 438). *Roe v. Wade*, most famously, established the right to abortion in 1973. Just as in *Griswold*, the Supreme Court decided that the right to privacy includes the termination of pregnancy (410 U.S. 113).

Although none of these Supreme Court decisions deal explicitly with assisted fertility or third party reproduction, they have implications for the field, notably the codification of the right to privacy in the arena of sex, pregnancy, and childbirth. This right to privacy can be interpreted as a right between adult couples, as well as between physicians and their patients, both of which are of paramount importance in reproductive decision-making, including whether or not use of reproductive technologies is of merit. Should a legislative body in the United States attempt to more actively regulate the uses of reproductive technologies or assisted fertility services, on par with the sort of regulations in nations such as the United Kingdom or Germany, it may conflict with some of these Court decisions.

State policies

Given that the United States is a federal republic, the majority of laws and regulations concerning reproductive technologies and assisted fertility services do not exist on a national level, but are in the hands of state government. The four main areas in which states individually regulate the industry are: state infertility insurance laws, regulations regarding disposition of human reproductive materials, and laws permitting or prohibiting surrogacy.

Table 3.3 States with laws regarding assisted reproductive technologies

State	Laws re: insurance¹	Laws re: gamete & embryo disposition²	Laws re: surrogacy³
Arizona			X (Prohibits)
Arkansas	X		X (Permits)
California	X	X	X (Permits)
Colorado		X	
Connecticut	X	X	
District of Columbia			X (Prohibits)
Florida		X	X (Permits)
Hawaii	X		
Illinois	X		X (Permits)
Indiana			X (Prohibits)

Louisiana		X	X (Prohibits compensated AI surrogacy [AIS])
Maryland	X	X	
Massachusetts	X	X	
Michigan			X (Prohibits)
Nebraska			X (Prohibits compensated)
Nevada			X (Permits)
New Hampshire			X (Permits)
New Jersey	X	X	X (Prohibits AIS; permits uncompensated IVF surrogacy [IVFS] only)
New Mexico			X (Permits uncompensated only)
New York	X	X	X (Prohibits)
North Dakota		X	X (Permits IVFS, prohibits AIS)
Ohio	X		
Rhode Island	X		
Texas	X	X	X (Permits)
Utah			X (Permits)
Virginia		X	X (Permits uncompensated only)
Washington		X	X (Permits uncompensated only; prohibits compensated)
West Virginia	X		
Wyoming		X	

Sources: 1. NCSL 2010, *State Laws Related to Insurance Coverage for Infertility Treatment*;

2. NCSL 2007, *Embryo and Gamete Disposition Laws*

3. Human Rights Campaign 2011, *Surrogacy Laws*

As I stated earlier, there are currently fourteen states that have laws regarding insurance coverage for infertility diagnosis and treatment. With the exception of California and Texas, these states mandate that insurance companies cover infertility treatments (albeit with many assorted exclusions). In California and Texas, insurers are mandated to inform employers about coverage, but are not mandated to actually cover infertility diagnosis or treatment (American Society for Reproductive Medicine 2011; National Conference of State Legislatures 2010).

A second set of state policies that vary widely concern embryo and gamete disposition. As of 2007, sixteen states have laws regarding the disposition of procreative materials: California, Colorado, Connecticut, Florida, Louisiana, Maryland, Massachusetts, New Jersey, New York, North Dakota, Ohio, Oklahoma, Texas, Virginia, Washington, and Wyoming. These laws cover such issues as informed consent, parentage, embryo donation for adoption or

research, destruction of embryos, disposition of sperm, eggs, and embryos in case of divorce or death, inheritance rights of offspring, personhood, and prevention of incest (National Conference of State Legislatures 2007).

California, for example, has several Codes and Statutes regarding the use of human reproductive materials. They require informed or written consent by a number of parties in different circumstances: by sperm, egg, and embryo donors for use of their reproductive materials in assisted reproductive technology, by infertility patients for disposition of surplus embryos after fertility treatment, and by egg donors for use of their ova in research. California law also prohibits buying and selling eggs for research purposes, entitles children to death benefits if they were conceived and born after the death of a parent (as long as informed consent had been obtained prior to death), and extends the right to petition the court for parentage to those who conceive using assisted reproductive technologies (National Conference of State Legislatures 2007). New York Code is much less extensive. It prohibits creating embryos using donor eggs and donor sperm except for use by a patient for her own fertility treatment, forbids creation of embryos using gametes of close blood relatives, and requires informed written consent by sperm, egg, and embryo donors (*ibid*).

Another area of policy in which there is no uniformity or harmony in the United States is the legality of surrogacy arrangements. As indicated in the last column of Table 3.3, some states have statutes that explicitly permit surrogacy and find valid the legality of contracts between surrogates and intended parents. Others have statutes that explicitly prohibit surrogacy and void all such contracts. Some have a blend, permitting some types of surrogacy and prohibiting others, or permit surrogacy but forbid compensation to the surrogate by the intended parents. Most states, however, have *no* statutes permitting or prohibiting gestational agreements, relying

on previous case law or on a case-by-case basis if an issue arise (Human Rights Campaign 2011)).

The biggest contrast between policies in New York State and California is how each state regards surrogacy. As Markens (2007) writes in her comparison of the two states,

New York's policy was constructed to discourage surrogate parenting; California's proposed policy was designed to regulate the practice in order to allow it to continue with as few problems as possible. More specifically, New York expanded its laws on adoption and the prohibition of baby selling to cover surrogate parenting arrangements, whereas California's approach to surrogacy was an explicit attempt to accommodate this new reproductive practice by circumventing existing adoption law. (4)

The contrasting policies have shaped the two states' fertility industry in divergent ways. Robin's explanation for why the fertility industry in California is so particularly robust is directly related to favorable legal climate for surrogacy that led to IVF doctors moving to the state, followed by egg donor and surrogacy agencies.

This favorable climate for surrogacy makes California attractive to those who live in regions (other states or internationally) where commercial surrogacy is not legal. In a nutshell, to quote Liam, in California, "there's no chance, or the chance would be so drastically slim, where a judge would ever award custody of your baby to the surrogate." Michael, family law attorney in California, calls the state "very surrogacy-friendly," explaining that "We have case law in California that's been decided by the Supreme Court indicating that intended parents going through assisted reproduction are the legal parents, providing they get a court order of parentage." This is *not* the case in New York, where surrogacy contracts are not recognized by the state.

Even among the states where surrogacy is legal, some providers recognize different *cultures* of surrogacy. Tammy, for example, noticed a difference between a program she worked for in Kansas versus the one she now works for in California. In Kansas, the whole process was

kept anonymous, and the surrogate and intended parents never met each other, not even at the birth. In contrast, she found that:

California really opened up and started to demystify and address the fear that people had of this being a real relationship, and being a relationship between parties that can work, with management and guidance. People can get together and start as strangers, and really do something important and special together. And I would say that that's been where CA has been a pioneer in surrogacy.

Although surrogacy is not legally recognized in the state of New York, providers do find ways around this. Dr. S, who has clinics in both New York and California, provides information about surrogacy at his New York clinics, but then clients fly out to Los Angeles for the actual surrogacy process. Even more conveniently, Dr. M's clinic has a "sister clinic" in New Jersey, where noncommercial surrogacy is legal. Dr. G states that his clinic does not "participate" in surrogacy, but, he explains, "It's just an open donation process, and from one couple to another woman, ... and then, they have surrogacy agreements amongst themselves and through surrogacy agencies outside of the state." Liz's clinic in New York City will provide gestational services, but only for cases where the surrogates are sisters or first cousins of the intended parents.

Lauren: Is that because of New York law?

Liz: The New York law is very tricky, and it's not anything that physicians usually want to take a chance with. Because the contracts are not recognized in New York State between the carrier and the biological parent, so the rights of the birth mother would prevail.

Lauren: And if it's a family member, then there's no need for a contract? Is that how it works?

Liz: Well, I mean, usually we also recommend that there's a contract, but if it's a family member, it's generally non-compensated, so it's the compensation thing, combined with the contract that we like to stay removed from.

As Liz and other providers told me, when in doubt, they consult with attorneys who are expert in family and reproductive law.

Industry Self-Regulation

In addition to the various levels of government regulation of reproductive technologies and assisted fertility services, the fertility industry is also self-regulated by the guidelines issued by its professional organizations. Two of the primary professional organizations, the American Society for Reproductive Medicine (ASRM) and its affiliate the Society for Assisted Reproductive Technology (SART), jointly dispense practice guidelines, positions, and opinions for their members on such topics as gamete and embryo donation, embryo transfer, laboratory standards, pre-implantation genetic diagnosis, and egg freezing. The SART website lists 24 Committee Opinions, 19 Educational Bulletins, 7 Guidelines, 5 Position Statements, 6 Technical Bulletins, and a Joint Report (Society for Assisted Reproductive Technology 2011).

The providers I interviewed claimed membership in these and several other professional organizations, as well as two non-profit consumer advocacy groups, indicated in Table 3.4. As a member of professional organizations, providers gain access to marketing resources (such as being listed in Internet databases available to the public), practice guidelines, policy updates, and professional status. The director of operations at a Los Angeles clinic told me that by being certified by professional organizations, her clinic looks “impressive” to other clinics—from her point of view, professional membership is a signal to others that one possesses a good set of morals. Membership and accreditation is a source for peer review and esteem.

Table 3.4: Organizations in which providers claim membership

Professional Organizations

American Society for Reproductive Medicine (ASRM)
Society for Assisted Reproductive Technology (SART)
American Medical Association (AMA)
American Congress of Obstetricians and Gynecologists (ACOG)
Society of Reproductive Surgeons
Society of Reproductive Endocrinology and Infertility (SREI)
American Bar Association (ABA)
American Academy of Adoption Attorneys (AAAA)
American Academy of Assisted Reproductive Technology Attorneys (AAARTA)
National Society for Genetic Counselors
Egg Donor Surrogate Parenting Association (EDSPA)

Consumer Advocacy Groups

American Fertility Association (AFA)
RESOLVE

Unlike government regulation, industry self-regulation is largely non-binding. The goal of guidelines and best practices is to provide guidance to professionals as they navigate some tricky procedures involving human life. Because these organizations do not have the force of law behind them, however, industry professionals are not legally required to follow the guidelines or opinions of their organizations. If a provider does not follow a state or federal policy, he or she faces the possible risk of criminal penalty, fine or loss of license. It is less clear what the consequences are of not following the professional guidelines, however. When I asked providers if they knew of any repercussions to going against ASRM/SART guidelines, they gave a series of contradictory responses. A New York physician stated that if you are not in good standing and do not “conform to a certain kind of conduct,” the organization “could kick you out. Reprimand you.” Yet a physician working in San Francisco said the precise opposite, that “SART doesn’t really have the power to sort of kick someone out. So when it comes to enforcement, yeah, you get a nasty letter from SART, and you can just tear it up (*laughs*). You can grow a thicker skin, that’s all you need to do.”

While several providers explained to me that in order to be a member of these professional organizations, one must comply with the guidelines, there did not seem to be any

greater repercussion beyond the stick of being, perhaps, a “pariah of the profession” (Dr. O). Overwhelmingly, the language that providers used indicates that absent the power of *law*, professional organizations do not exert much control over individual practitioners:

Michael (attorney): *There’s no meat and bones behind [the guidelines].*

Dr. G: *You don’t go to jail if you didn’t follow guidelines.*

Dr. M: *I mean, there’s no law that makes you follow the guidelines.*

Despite their cynicism about the role that their professional organizations play in self-regulating behavior and practice, many providers still expressed positive messages about the guidance and associated benefits they gained through membership. Sometimes this came across as a kind of double-speak, or maybe just lack of reflexivity. Dr. C, for example, claimed that professional organizations “do not have the power to shut somebody down,” but still sees them as forces for self-regulation: “I think it works in that while mistakes can be made within our system, they get resolved. They get out, the group that has the problem is identified, and within the system we work to improve that group.” From Dr. C’s perspective, the system is “functional” and works through negative sanctions reinforced by other clinics and providers. If word gets out that there is a group that is not following the standards of their profession, it may not be “shut down” through any formal or legal mechanisms, but others in the field will choose not to work or collaborate with them.

This kind of extralegal professional normalization also applies beyond the medical and legal fields. While physicians and attorneys (and also the clinical social worker and genetic counselor I interviewed) are licensed and regulated by the state and their professional organizations, they do not make up the entire workforce of the fertility industry. If we take into account all of those who own and work at egg donor and surrogacy agencies, we can see that

there are huge swaths of this industry working entirely free from professional *or* government regulation. If agencies want to be listed on the ASRM website, they must comply with ASRM guidelines, but there is no *obligation*, legally or professionally, to do so. Some clinics and doctors require that egg donor and surrogacy agencies sign documents attesting that they will comply with ASRM guidelines—but again, agencies are not obligated to work with those clinics or doctors.

Nor is there currently any licensing of egg donor or surrogacy agencies in the United States, although several providers argued in favor of the creation of such licensing programs. Robin, for example, imagines that licensing could serve as “a sort of Good Housekeeping seal of approval.” She believes it would help protect vulnerable intended parents from being exploited, and help them assess the quality of programs. Other providers pointed to recent scandals in which surrogacy agencies absconded with millions of dollars given to them by intended parents for donor and surrogate services that were meant to be transferred to surrogates and egg donors (see also Saletan 2009; Yoshino 2009). Dr. S blames the lack of professionalism and government oversight for these rogue agencies:

In order to be a surrogate agent, all you need to do is buy a business license for \$10, put it up on the wall, and you’re a surrogate agent. No professional training, no educational requirements, nothing.

He has written to the California legislature about this problem, saying “Listen, there’s twenty more like this,” but has yet to get a response.

Deirdre, an attorney, who spoke of how her legal license keeps her accountable to her clients and the surrogates they contract with, is ambivalent about licensing egg donor and surrogacy agencies:

I tend to be more the anti-government licensing thing—I don’t like a lot of bureaucracy, because they tend to put in regulations that are not enforceable or they don’t know what

they're doing. But it would be nice to have some oversight. But, we also have the economics. The government doesn't have the money to oversee all this stuff, so what good is regulation if the regulation is violated and you can't get anyone to prosecute it?

Shelby and Rebekah are also ambivalent:

Rebekah: There are pros and cons. I'd like to see some kind of self-regulatory board. Not government licensing. You know, if there had been licensing when I started my company, I'm sure I wouldn't have fit into the requirements, you know? Now, we are probably, I don't want to say *the* most reputable, but *among* the most reputable agencies out there. There are other good ones, is what I'm saying.

Shelby: And so we would probably be able to get licensing.

Rebekah: Yeah.

Shelby: But, the start-up wouldn't.

Rebekah: ... I think there needs to be some sort of guidelines that people are going by, and we just set our own.

Providers continually made arguments for self-regulation from within the industry, but they did not always make this argument without apprehension or trepidation. Tammy, the social worker, for example, summed up the situation as a "kind of double edge" when it comes to insuring safety for all parties involved: the industry is capable of causing harm to people, but if it is "over regulated" by lawmakers, the industry may be too confined, which could also harm intended parents. This is precisely the argument that Dr. C makes when he told me that when governments in other countries impose standards, "the care has disappeared."

Again, this fear of government regulation was not only expressed by physicians. One surrogacy broker expressed that she "would never trust" elected officials to make policy about assisted reproduction, and another said that government involvement is her "biggest fear." Deirdre said that she "[does] not particularly like government regulation." She is working with other attorneys to establish a national standard of care created by practitioners in the field because she "did not want the government to come in and regulate, regulate, regulate."

There is an inherent contradiction here. Many of the providers I interviewed argued that the fertility industry should self-regulate, without arduous interference from government regulation, yet at the same time they express ambivalence about the effectiveness or even existence of enforcement mechanisms. As I indicated earlier, providers expressed wariness about lawmakers and bureaucrats making policy in areas in which they lack the specific expertise (particularly medical expertise) that they believe is necessary to help intended parents have children—or, in other words, that would interfere with the way they conduct business. This attitude may not be unique to Americans, yet skepticism about government and belief in the triumph of market forces aligns with neoliberal or free market ideologies, a trait that is inherent in American politics.

CONCLUSION

I sat down with twenty fertility industry professionals in three cities to talk about their work as United States providers in an emerging global market. Their descriptions of the United States fertility industry, digitally recorded and transcribed, began to form a collective portrait. Providers spoke of a technologically robust landscape, with medical breakthroughs, new techniques, and better success rates. They saw this field growing exponentially larger—locally, nationally, and internationally. More clinics and agencies are popping up, leading to increased competition, but the demand for assisted fertility services is also constantly on the rise. Those who had been working in the field since the 1980s witnessed changes in public attitudes regarding assisted reproductive technologies, seeing them more accepted, commonplace, and open, rather than something to fear or hide.

The providers also spoke of shifts in laws and regulation, of having to be on top of policy

changes in several different arenas and regions. They expressed feelings of being burdened by paperwork and bureaucracy, of being over regulated by policies that came down to them from the state, the federal government, and their professional organizations. Although they had concerns about the industry, and were cynical about how easy it is to ignore professional norms, many were fearful of government interference, and desired keeping regulation of the field within the industry itself. Ironically, the regulatory playing field in the United States, when compared to other nations, is quite laissez-faire. On some level, the providers understand this, as they repeatedly told me that their international clients come to the United States because of overly strict regulation in their own countries. While they may not be currently clamoring for *less* regulation, most providers are happy with the regulatory status quo: keeping the fertility industry privatized, and the government out of their business.

Chapter Four

“You Don’t Go to Jail if you Didn’t Follow Guidelines”: Ethics, Professional Autonomy and the United States Fertility Industry

“[Professions] characteristically seek the freedom to manage their knowledge and work in their own way, protected from lay interference. Indeed, they celebrate the ideal of men who may be trusted to control their own affairs responsibly and in the public interest.” – Eliot Freidson (Freidson 1988:xii)

Assisted reproductive technologies have been mired in controversy since at least the middle of the twentieth century, when researchers first began exploring ways to assist infertile couples that involved fertilization outside of the human body (Henig 2004). New reproductive and diagnostic technologies such as *in vitro fertilization* (IVF), intracytoplasmic sperm injection (ICSI), chorionic villus sampling (CVS) and pre-implantation genetic diagnosis (PGD), developed by scientists and clinicians in the laboratory and the surgical theater, have been met by fear, revulsion, and outrage, or, alternatively, enthusiastically embraced as signs of progress. These opposing worldviews get institutionalized in the form of governmental policies, religious decrees, and organizational mandates.

In this chapter, I contribute to the discussion about ethics and assisted reproductive technologies by focusing on the perspective of people working from within the American fertility industry, in the context of a global landscape where much of the work they do is banned or highly regulated elsewhere. Outside the United States, many nations restrict and regulate what types of reproductive technologies may be offered within their borders, and what types of people may have access to them. These restrictions and regulations, such as those outlawing surrogacy or sex selection, are largely based on a presumed (or imagined, in the Andersonian sense (Anderson 1991)) set of collective or national ethics. The few federal regulations in the United

States that exist deal primarily with laboratory and tissue handling procedures and the collection and publication of success rates, and one can argue that these, too are driven by ethics that place a value on consumer safety, choice, and informed consent. These regulations do not, however, rest upon deep-seated moral and religious questions such as when life begins, or what one can or cannot do with one's body for money, or pass judgment on what types of people may partake in a medical procedure or economic transaction. This is not to say that those moral questions are settled in the United States, or are not fraught with politics; on the contrary, laws and policies regarding abortion, assisted suicide, and medical marijuana show that different levels of U.S. government frequently do take positions on these weighty matters and, as it were, legislate morality. Moreover, as I elaborate in Chapter 3, regulation is not non-existent, but rather governance over these technologies is decentralized and fragmented, and primarily rests with states and more localized government bodies.

Several fertility industry professionals I interviewed expressed to me the idea that even with the decentralization and fragmentation of policies, there is still, in essence, an American style of ethics that guided their work. As one physician articulated as we sat in his office on the Upper East Side in Manhattan, there is a difference between "American" ethics and "European" ethics, namely that ethics in the United States center on the individual, whereas Europe focuses on the collective. He gave as an example the contrast in the free market organization of health care in the United States as opposed to the socialized medical systems in many European nations. When the state is paying for the medical services of its citizens, it has more of a stake in determining what it is willing or unwilling to pay for. This point, one can argue, is one of the cudgels that American conservatives used in the recent health care debates: any movement towards a more "socialist" form of health care, in which the government assumes a greater

financial responsibility in paying for medical services, may lead to government overriding medical decisions made between physicians and their patients. In our current privatized system, it is insurance companies who more often wield this power to override medical decisions.

Significantly, federal regulations in the United States are aimed at the medical and scientific professions, and not at the individuals who wish to obtain fertility services. This is quite contrary to policies that exist elsewhere that forbid, for example, an infertile couple from paying a woman to gestate and give birth to a child for them, or that demand that all gamete donors be registered in an accessible, national database. The individual in the United States is free to consume the services she desires, whereas her embryologist, reproductive endocrinologist, and lab technician are bound by law and policy to follow certain procedures. When I began interviewing providers of fertility services—particularly physicians and others employed at clinics—I was surprised by how burdened many of them felt by rules and regulations. Was not the United States, after all, one of the most *laissez-faire* of all countries when it comes to assisted fertility services? From the point of view of their European counterparts, many of whom are not able to offer the same services that American providers can, the United States may seem like a free-for-all. But, from the American point of view, reproductive medical practice is guided by layers of bureaucracy—federal *and* state regulatory systems, professional guidelines, and health insurance policies.

All of the providers I interviewed—physicians, attorneys, office managers, social workers, egg donor and surrogate brokers—were aware of how ethically fraught the work they conduct is, either on a micro, day-to-day basis, or on a more macro, long-term, wide-ranging level. Although they may not be constantly mulling over philosophical problems in the course of their daily business, when asked about concerns they had with their industry, or questioned about

which constituencies should have a voice in making policy, many expressed answers that reflected that they *had* considered these ethical questions; some even described getting into debates with their colleagues over them.

In this chapter, I discuss ethical questions surrounding reproductive technologies as they are practiced within the United States. Again, my focus is on both reporting and analyzing what the providers I interviewed told me when pressed to think about questions of ethics and morality. I begin with a discussion about why providers believe that ethics are relevant to their work. Next, I discuss the ethical issues that arise with specific technologies or uses of technologies, and how the way that American providers approach these issues contrasts with that of their colleagues abroad. Third, I describe how fertility industry professionals confront ethical problems in their daily practice as moral gatekeepers. Finally, I conclude with a discussion on the implications that these conversations about ethics have in the context of the concept of reproductive autonomy.

WHY ETHICS MATTER

From the perspective of some fertility industry professionals, ethics and regulation are two separate issues. Whereas all of the providers I interviewed agreed that their work is fraught with ethical issues, this did not necessarily translate into a belief that their field demands regulation or government oversight. On the contrary, many expressed the idea that ethics are either a personal matter to be reconciled by each individual, or that questions of right-and-wrong, when they have to do with medical procedures, should ultimately be left up to the medical profession. Regardless of their opinion on the role of government in legislating ethics (which will be explored further below), fertility industry professionals understand that significant ethical issues are at stake.

The Nature of the Technology

“I think you have to go to the important ethical principles that we all live by, and that we use in medicine all the time. *Do no harm.*” – Dr. H

According to assisted fertility providers, their work demands special attention to ethical concerns because the nature of reproductive medicine and of the technology itself is imbued with risk and the potential for negative outcomes for intended parents, third party donors, offspring, and society at large. For example, Dr. B, a New York physician, cited the risks involved in tissue transfer between people. As with blood transfusions and organ transfer, technologies such as artificial insemination, egg donation, and surrogacy may put the person receiving the tissue (either an intended mother or a surrogate) at risk of disease. Additionally, the disease risk associated with reproductive technologies extends both bodily and temporally, in that any resultant offspring are also at risk of contracting disease from infected tissue. This concern with reducing the risk of transmitting disease through tissue transfer is, as noted in Chapter 3, addressed by the federal government through regulations ordered by the Food and Drug Administration and the Centers for Disease Control.

The technology is also inherently risky because it involves the creation of human life. Dr. H, a physician in the San Francisco Bay Area, goes further than Dr. B in his description of why it is in the “nature” of reproductive medicine that it is, in his estimation, “probably more” regulated than other medical fields, with the obligation to obtain and maintain a number of licenses and report outcomes that other fields do not require. Yet, even more than the “intricacy” of his practice, there are deep ethical issues concerning the creation of human life, and all of the potential pitfalls involved in that creation:

If you mess that up, you've got a whole life, a whole human life that is going to be affected. Yes, if you mess up the surgery for an orthopedic surgeon, you may have somebody who limps for the rest of their life, and that's pretty terrible, too, but you're not making baby after baby after baby. (Dr. H, physician, SF)

Reproductive medicine is unique in at least two respects: (1) It involves the *creation*, not merely the maintenance, of life, and (2) It involves *elective* procedures. These two distinctions contribute to the belief that assisted reproductive technologies are more risky, consequential, or in need of surveillance. Many of the physicians recognize the lifelong impact that their practice has on their patients and any offspring they have a hand in creating. This idea that they, unique among medical practitioners, are dealing with long-term issues of "creating life," leads many to conclude that their field requires at least some regulation. Other fertility clinic employees paid more attention to the distinction between elective and non-elective medicine. Liz, for example, an egg donation coordinator at a large New York fertility clinic, contrasts her work with other medical practices that perform life-saving work. She wonders about the types of ethical conversations that are involved with brain surgery, for example. "I don't know if they have the same sort of discussions that we have about 'Should we even do it, or not, for this patient?'"

This feeling that reproductive technologies are more risky or consequential than other fields was echoed by a number of fertility industry professionals. All medical procedures involve some measure of iatrogenic risk, but those risks are usually limited to the patient; likewise, all pregnancies also involve risks, but these risks are usually limited to the mother and fetus. In the case of third party reproduction, the parties at risk extend beyond intended mothers and fetuses to include donors and surrogates, which is another reason why the ethical concerns run deeper in reproductive medicine than in other fields. Anne, who works at a surrogacy agency in Los Angeles, cites these risks as a reason for why ethics need to be employed in screening potential clients who want to use her agency's services. Invoking the famous medical mandate to "Do no

harm,” Anne argues that her agency demands that there be “a justifiable medical reason that somebody needs the help of a surrogate. It can’t be because you’re a famous actress. We’re asking another [woman] to risk her life, perhaps voluntarily, but albeit, to risk her life, for somebody else’s inability. It better be real. It better be for a real inability.”

The principle to “Do no harm” was cited by a number of other professionals. Dr. O, a fertility doctor in the San Francisco Bay Area who works with a largely Asian and Asian American clientele, contemplated whether or not this principle was being honored. When I asked him about any concerns he had about the industry, he paused and, with eyebrows furrowed, verbally struggled with whether or not his profession causes harm, or is even coercive, to surrogates and egg donors:

Is it really ‘Do no harm’ having somebody carry your children? Probably, but on the other hand, is that a benefit? ... If you want to pay somebody, they can do that, pay \$50,000, go to Harvard, recruit a nineteen-year-old girl. ... But is it really right? Does that constitute egg *donation*, or is that coercion? Or is that just a friendly purchasing of human body parts?

“Are we doing the right thing?” Dr. O asked, rhetorically. Note also how his point of view keeps shifting, where it is not always clear whether or not “we” or “you” refers to himself and other doctors, to his patients, to me as the interviewer, or to an abstract interlocutor. “I guess that’s the ultimate question: are we doing this, defying nature, or defying God. ... As long as you pay you get whatever you want. Sometimes you think about it.”

By invoking the ethic to “Do no harm,” both Anne and Dr. O highlight one of the ambiguities of third party reproduction from the perspective of the medical provider: who, exactly, are the doctor’s patients? Are they the people who pay him to extract and handle other people’s gametes, or are they the people whose gametes are being extracted and handled? Are they the people who plan to take home a baby, or the people whose bodies will carry and nurture

that child for nine months? That is, is the doctor's patient the person who pays, or is it every person whose body is under his care? Without a clear understanding of who he is "treating," the principle of "Do no harm" is an insufficient guide that cannot reconcile the fact that all the parties involved—intended parents, donors, surrogates, and the physicians themselves—may have conflicting interests. Indeed, the situation demands that physicians not regard donors and surrogates as full patients. Given his conflicted feelings about egg donation and surrogacy as potentially coercive, if Dr. O viewed donors and surrogates as his primary patients, would he be obligated to advise them not to put their bodies at risk, effectively limiting a large source of his income? As Freidson (1988) reminds us, medical professionals are not disinterested parties, but their practice is guided by economic, social, and professional interests.

This ambiguity exemplifies a problematic aspect of reproduction in the post-modern age, at once both medicalized and commodified. The medicalization of reproduction, including pregnancy, childbirth, and infertility, has transformed intended parents into *patients*, requiring the expertise of physicians and other medical providers (Jordan 1993; E. Martin 1987; Rothman 2000). In the trajectory of infertility treatment, intended parents often begin their relationships with their physicians as typical patients whose bodies are palpated, examined, diagnosed, prescribed to, operated on, and so on. This trajectory leads to more and more aggressive medical treatments, usually on the intended mothers' bodies (Becker 2000; Franklin 1997; Thompson 2005), but may also extend beyond the initial patients' bodies into the bodies of others—sperm donors, egg donors, and surrogates.

Medical sociologists have described the process of medicalization as a form of social control (Conrad 1992; Zola 2009). As Ehrenreich and English (2010), Martin (1987), Jordan (1993), and Rothman (2000) have all argued, the medicalization of pregnancy, childbirth, and

other bodily processes has shifted control over women’s bodies from women themselves to physicians and other medical authorities. Similarly, Frank (1997) writes of medicine colonizing the body, of patients ceding territory to their physicians. This medical colonization hovers over the intended parents’ bodies even after physicians determine that more treatments on their patients’ own bodies would be fruitless. As long as they are still under counsel of their physician, the intended parents do not cease being patients, even if other bodies are brought in as substitutes. In Parsonian terms, they still fulfill the “sick role” (1951). They have been diagnosed as incapable of a biological function, and require the care of a physician. It is only when they exit the medical system—by turning to adoption, foster care, or resigning themselves to childlessness—that the intended parents cease being patients.

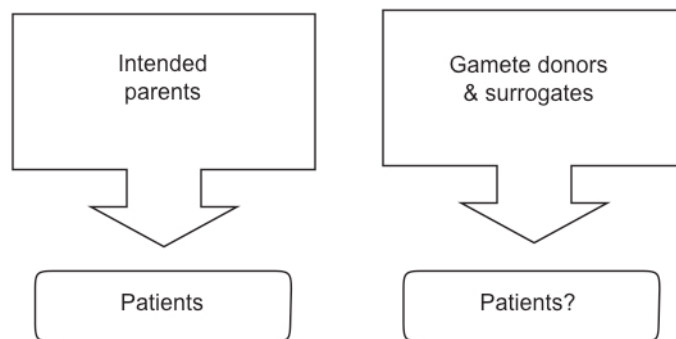


Fig. 1: Medicalization

Gamete donors and surrogates are not *medicalized* in the same way that intended parents are. While the bodies of intended parents who are unable to procreate “naturally” either because of a biomedical condition or social status are regarded as deviant for their inability to be productive, the very productivity of gamete donors’ and surrogates’ bodies marks them as normative or even *super* normative. To extend the earlier metaphor, their bodies are not colonized by the medical system because of a deviant status; rather, the colonization of their bodies results from the medicalization of *other people’s bodies*, like so much collateral damage.

Gamete donors and surrogates do not fulfill the sick role. Although their bodies, too, are palpated, examined, and operated on, patient status does not fully extend to them (fig. 1). Instead, their status is more ambiguous—it is somewhere in between patient, employee, and sole proprietor (Waldby 2008).

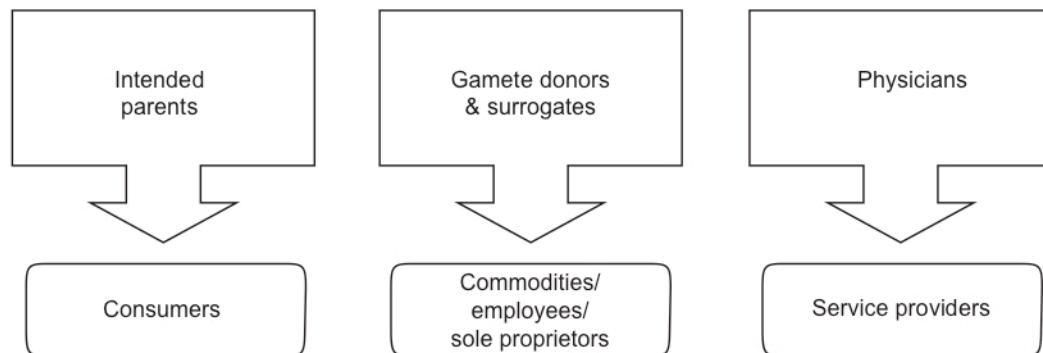


Fig. 2: Commodification

This points to the second half of the medicalization/commodification equation (fig. 2). At the same time that procreation has become medicalized, transforming intended parents into patients, so have intended parents also been transformed into *consumers*. Although many may be loath to think of bodies or children in terms of commodities and markets, reproductive technology in the past thirty years has been remarkable for its fragmenting of the procreative process, enabling elements to be divided up and outsourced to various parties. Further, despite the medicalization of infertility, fertility treatments are still considered to be *elective* treatments. Being able to take home a much-wanted child may very well contribute enormously to one's well-being, but infertility is not a life-threatening condition. Intended parents do not only consume the fertility services that their physicians offer them, but they may also consume body parts such as sperm and eggs, and/or the labor of women acting as surrogates. Thus bodies and body parts have become commodities, physicians are also service providers, and donors and surrogates are employees/sole proprietors.

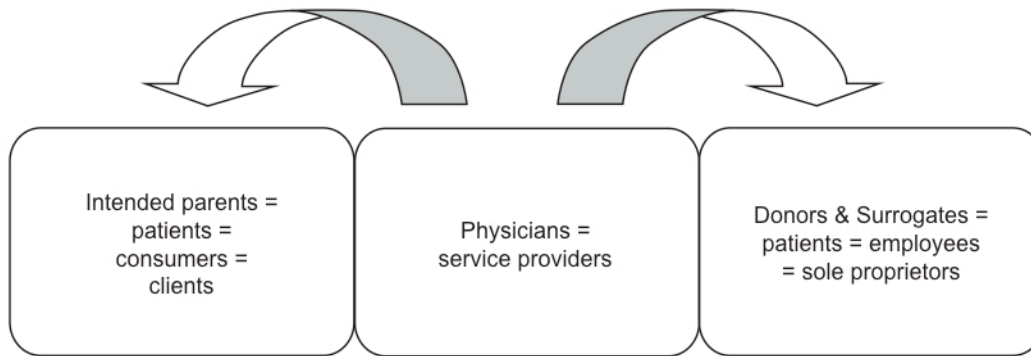


Fig. 3: Tangle of roles and statuses

This tangle of roles and statuses (fig. 3), I argue, of intended parent/patient/consumer, physician/service provider, donor-surrogate/patient/employee/sole-proprietor, is one source of the ambiguity raised by the “Do no harm” ethic. In a simple one-to-one patient-physician relationship, the mandate of nonmaleficence is not necessarily always unambiguous, which is why many medical practices, including some of the ones where I conducted interviews, convene ethics boards or committees to negotiate the complicated ethics of various medical treatments. Complicating matters even more, however, is that in the realm of reproductive medicine, the fact that third parties are involved muddies that strict patient-physician relationship, where the physician may not wish to do harm to the intended parents by denying them treatment, but may not necessarily consider the possible harms that donors and surrogates are being put at risk because they are seen as adjuncts to procreation rather than as patients. In addition, the huge sums of money involved in fertility treatments may cloud the ethical judgment of some physicians.

The non-medical providers that I interviewed faced similar ethical dilemmas in terms of their ambiguous relationships with clients, donors, and surrogates. As far as attorneys go, the ethics about whose needs they represent are clearer for them than they are for medical providers.

That is, both attorneys I interviewed understood that in cases involving third party reproduction, they did not—and ethically *could* not, by the standards of their profession—represent intended parents *and* the third parties they contracted with, because this would be a clear conflict of interest. The waters get decidedly murkier among some of the other providers, however, especially those who work at egg donor and surrogacy agencies. These are not “professions” in the same way that medicine and law are professions: they are not high status occupations, are not highly organized, do not require special education, do not have closed or limited entry, and, in the United States at least, are entirely unlicensed and unregulated. Neither is there any set of professional ethics that is particular to egg donor and surrogacy agencies, such as a mandate to do no harm. Their role is intermediary and transactional—to screen and match suitable donors and surrogates. Egg and surrogacy brokers rely on physicians to insure that their clients’ medical needs are met, and rely on attorneys to insure that their legal interests are met, and therefore it is beyond their call of duty to judge whether their clients are requesting something that is not to their benefit.

As far as their relationship with the donors and surrogates they recruit, screen, match, and transfer money to, the egg and surrogacy broker is in an ambiguous role—somewhere in between boss and advocate—almost like a head hunter or temporary employment agency. Brokers are paid handsomely by their clients, but it is also in their interest to insure that donors and surrogates have safe, fair and pleasant experiences—if only to retain a pool of people willing to donate or carry a child again in the future. This is especially important given that donors and surrogates who have proven “successful” in the past garner a higher sum than first-time donors and surrogates. As the mediator between the client and the donor-surrogate, the broker represents both; unlike the attorneys, brokers do not recognize the conflict of interest inherent in the nature

of these relationships. Although some brokers spoke of wanting to protect “their” donors and surrogates, as I describe in detail in a later section, they were more likely to express the need to protect their clients (i.e. the intended parents) from donors and surrogates who, in their opinion, sometimes over-charge for their services.

The potential to ‘spiral a bit out of control’

Another thread that runs through several of the providers’ testimonies is the idea that without strong ethical principles (or, for some, strong regulation), reproductive technologies have the potential to go—and have, at times, gone—horribly wrong. They use language such as “things getting out of hand,” “spinning out of control,” and even “a complete disaster for human beings.” A fertility doctor in New York who I interviewed presented to me several scenarios that seemed to come right out of science fiction. When I asked him about any concerns he had about this field, he replied, “We use technology that if not used carefully could be used in a malicious way.” He cited cloning as one example, and embryo splitting as another, in which you “implant one embryo and freeze the other” for future stem-cell purposes.

Another problem inherent in the nature of the technology is that some scientists and practitioners of reproductive medicine may make unsubstantiated claims. Rebekah and Shelby, co-founders of a Los Angeles fertility consultation group, spoke of “fringe doctors” who make unrealistic or patently false claims about experimental technologies and their success rates. Others spoke of “quacks” that they tried to warn their clients away from. Because this technology sounds like science fiction to those of us who are not highly trained experts in the field, there is a fear that practitioners may get away with doing harmful things, and that those

who are desperate to have children may be gullible to falling for some of the false claims made by scientists and clinicians.

One might think that government oversight of reproductive medicine could be a solution to these problems of wrong-headed science and false claims. Yet several of the providers I interviewed—even those who had just spoken of the ethical problems inherent in the technology—would rather trust scientists and physicians to self-regulate than they would trust politicians to establish policy. For example, Tammy, a Bay Area social worker employed by a surrogacy agency, takes an almost defeatist position about regulation, arguing that “It still is an industry that, put in the wrong hands, could cause harm to people. And has caused harm to people. You know, but what can you do about that?” She believes that lawmakers who do not understand the science should not be making policies that regulate it. Further, regulation would “confine people too much, and that could definitely hinder some couples in having the best chance for success.”

Tammy, as someone who does not herself practice medicine, is willing to trust and believe in the authority of medicine. Ironically, this stance contrasts with that of Dr. B, who, as a physician, is less trustful of his colleagues. Throughout my interview with him, he continually railed against the burden of bureaucracy (so much so in fact, that I asked him if he had ever read Kafka), yet he was also a strong proponent of regulation as a check against the potentials of things getting “really spun out of control.” Such contradictions were present throughout many of my interviews. Anne, for example, sounded like a cheerleader for regulation of surrogacy agencies when she stated “I would love more regulation. I think it’s ethics. I think ... people would benefit. ... I go back to the fact that if you do good work, bring it on. Bring on the microscope.” Yet she does not want to see oversight of surrogacy agencies extend to oversight of

medical practices. When it came to the specific matter of setting a standard for how many embryos may be transferred during IVF, she evinced complete skepticism that government should be involved: “Oh god, I would never trust [politicians]. I just think that it should be a conversation amongst the people who are the experts.”

There is thus a continual tension among the provider testimonies—and within them, as well—about how to deal with the potential pitfalls of their industry. Rebekah reflexively recognized the internal contradiction, and joked about being politically liberal on most issues, but not when it comes to the matter of regulation of the fertility industry:

I said to myself, ‘Oh my god, I’m a Republican in that area!’ I think there needs to be more self-regulation and governance from the professional organizations. I think they absolutely need to step in, because if they don’t, the government’s going to.

As an example, she cited recent scandals in which surrogacy agencies have absconded with hundreds of thousands of dollars of their clients’ money, leaving pregnant surrogates and heartbroken intended parents in their wake.

Related to the notion that reproductive technologies have the potential to “spin out of control” is another frequently named fear that providers encounter, namely that physicians are, in effect, “playing God.” Jen, a genetic counselor in New York, counters this argument, stating that her training in what is scientifically possible sometimes conflicts with patients’ desires: “I think there’s a lot of things that are really out of people’s control, and I think that the technology will show us that. As more tests become available, we’ll still understand, we’ll learn more the limitations of what we still can’t test for. And that we can’t really play God, although that’s what people think we are doing (*laughs*).”

ETHICS OF PARTICULAR TECHNOLOGIES

There are technologies and procedures that are common and legal within the United States that are banned, criminalized, or highly regulated in other nations. Fertility industry professionals shared with me their perspectives on the ethics of various technologies and procedures, including financial compensation for donors and surrogates, disclosure issues and anonymous donation, embryo transfer, sex selection, and genetic screening.

Financial compensation for donors and surrogates

Several nations, including Austria, Germany, Italy, Japan, and Switzerland, prohibit egg donation. In other nations, including Australia, Belgium, Canada, Israel, and the United Kingdom, egg donation is legal, but only if it is truly a “donation”; that is, *commercial egg donation*, or selling eggs, is prohibited. Similar prohibitions exist throughout the world regarding surrogacy—outright bans in some places, and bans on commercial surrogacy in others. One of the distinctive features of the United States fertility industry is its lucrative market for ova and surrogates, and the complete lack of government intervention in regulating compensation structures. Absent government policy, the fertility industry self-regulates the egg donor and surrogacy markets. In 2007, the American Society for Reproductive Medicine (ASRM) Ethics Committee published a report outlining guidelines regarding financial compensation of oocyte donors (Ethics Committee of the ASRM 2007). These guidelines provide ethical justification for compensating egg donors for their “time, inconvenience, and discomfort associated with screening, ovarian stimulation, and oocyte retrieval” (p. 305), and demand that donors receive information and counseling as part of an informed consent procedure to prevent “inappropriate decisions to donate oocytes” (ibid.). What is perhaps most interesting about these guidelines are two additional points: first, that physicians are to regard donors as “any other patients,” which, as

indicated by my interviews, they do not necessarily uphold in practice. Second, these 2007 guidelines attempt to set a price on a woman's eggs: "Total payments to donors in excess of \$5000 require justification and sums above \$10,000 are not appropriate" (ibid).

Others have written extensively about the problematics of egg "donation" and the commodification of body parts (Gimenez 1991; Spar 2006; Steinbock 2004; Waldby 2008; Waldby and Cooper 2008). While that is an important part of the conversation, we must also pay attention to the "disconnect" between the ethical justification made by the ASRM and views about compensation held by individual providers. In the discussion by the Ethics Committee about unreasonably high compensation, the primary issue appears to be that of coercion: if donors are offered huge sums of money for their ova, is this not an unethical inducement to young women to put their bodies at risk? Yet the amounts of money that the ASRM finds reasonable and justified in the United States far exceed the more highly regulated amounts that have been legally established in countries such as the United Kingdom. In the language of the Human Fertilisation and Embryology Authority (HFEA), sperm and egg donors in the UK should not be "paid" for their gametes; rather, they may be reimbursed for expenses for lost earnings up to £250 (approximately \$390 in U.S. dollars), per cycle (Human Fertilisation and Embryology Authority 2011a). This reimbursement structure, it should be noted, is currently under review at the HFEA (Human Fertilisation and Embryology Authority 2011c). Low reimbursement rates have contributed to shortages of egg and sperm, leading intended parents to travel abroad—to places such as the United States—where donated eggs and sperm are more highly compensated, and also more abundant (ibid).

While the same ethical concerns about coercion and the commodification of body parts may lead both the HFEA and the ASRM to cap donation cycles, the monetary differences

between those caps are striking. If you do not pay donors enough money to make donation worth their time, most will not donate. However, if you pay donors *too much*, it is possibly coercive or devaluing of human life. This conversation about the merits and ethics of compensation assumes that egg donation *itself* is viewed as ethically justified, unlike in countries like Italy and Germany, where it is completely banned. Commercial egg donation may be banned in the United Kingdom, but egg donation itself is not. The market for ova, thriving throughout the world, not only shifts to those countries where egg donation is permitted, but the largest markets exist in those countries where *commercial* donation is permitted. The United States, despite guidelines by the ASRM (a non-governmental organization), does not regulate how much money an egg donor can receive per cycle, and rumors abound about Ivy League donors, for example, auctioning off their ova for the price of one year of tuition. Although the going rate of \$5000 to \$8000 per cycle may seem excessive, those high costs also create an incentive structure for young American women to donate that does not exist in places where they are less handsomely compensated. The ethics behind the United Kingdom's compensatory structure is thus more logically consistent than that of the ASRM. If young women will not donate because they are not being paid enough to do so, then is this not a sign that donation is indeed a commercial transaction and not an act of altruism?

The providers I interviewed, at least, recognize the commercial nature of the transaction, some of them seeing the market as a necessity, such that, as Dr. C argues, without a market for eggs and surrogates, services would disappear in the United States, as they have in other nations: "If you want egg donation to exist, we've got to pay donors. If you want gestational carriers to exist, you've got to pay gestational carriers. And the market forces have established a price, which is a reasonable thing. It's a functional system. It works great." His colleague, Dr. H,

argues similarly that “just with a wipe of a pen”—that is, if legislation were to pass banning commercial egg donation in the United States—egg donors would no longer be willing to donate, and infertile couples requiring egg donation would no longer be able to have children. Rather dramatically, he states, “[If] they pass a law saying we can’t pay egg donors, that’s just the end of it.”

Although Dr. C and Dr. H express compassion for intended parents who require the services of egg donors and surrogates in order to have biological children, as fertility doctors they are not disinterested parties; after all, were the market for egg donors and surrogates to disappear, so too would their own industry shrink. This is not the only justification given for paying egg donors and surrogates, however. Anne, who had had two children through a surrogate herself, argues from a feminist and civil libertarian perspective that it is unfair to expect donors and surrogates to supply their services altruistically:

Men have been paid to do things, but nobody blinks an eyelash. Nobody says, “Oh! The fire department’s arrived to put out my burning house. You’re doing this for free, though, right, ‘cause I mean, you’re saving my house and it’s a good thing, right?” ... Nobody questions that. ... So why can’t women be paid to donate their eggs? Why can’t women be paid to be a surrogate?

Others argued that it is only fair and just for third parties to be paid for their time and labor.

Although my interview pool did not expressly include surrogates or egg donors, one agency in Los Angeles that I visited is unique in that all three employees had themselves been egg donors, thus they had a different perspective from many of the other providers that I interviewed. Megan, the marketing director for this agency, gave a thoroughly reasoned argument for compensating donors well: “If you’ve never been a donor before, you do have to do a lot of things. You have to go to doctor’s visits, and you’re injecting yourself with things, ... And I think sometimes the question about why should she be paid so much, it’s like, have you ever been through this? Do

you even know what they have to go through?”

Yet compensating donors is not viewed by all as an absolute good. Dr. O worried about the coercive nature of egg donation, and spoke of those who donate eggs “for obviously financial benefits.” Tammy also brought up “the coercion factor,” which she sees as a particular issue for young women who could use the money for college. As she put it, “A lot of people would do a lot of things for \$50,000, \$100,000. I mean, how could you say no? ... So, it’s really making it difficult for them to think objectively about should they do it, because they’re in the moment.” Aside from religious dictums about the sanctity of life or worries about the commercialization of human body parts, these qualms about the possible exploitation or coercion of egg donors seem to be a primary factor in other countries’ laws prohibiting financial compensation for ova.

Some providers also worry about the flip side—the exploitation of intended parents by the donors. Like several of the providers that I interviewed, Rebekah and Shelby had personal experience as intended parents, both of them having had children through third party reproduction prior to opening their agency. This dual experience as both intended parents and egg and surrogacy brokers may inform their negative talk about “egg donation fees getting out of control.” Shelby cited one client who paid a donor what she described as an outrageous sum of \$25,000 for a first-time donation, on top of the additional fees they needed to pay the agency that coordinated the donation cycle: “You know, the truth is, some people don’t care about what they’re getting as long as it’s healthy. Other people, like us, did care. I want to know more about my donor, and I’m going to pay more for things that I think are important. Would I pay 25,000? No, I think that’s nuts.” In this example, Shelby’s primary concern is that this was the donor’s first experience with donation. Experienced (or “proven”) donors, in her point of view, do merit higher compensation.

Despite Dr. C's support for market forces, other providers, such as Dr. B in New York City, argue that compensation rates should not be market-driven. His and other providers' concern about market forces driving compensation, however, is not about the commercialization of human life. Rather, arguments against the market are actually arguments against the control of the markets *by donors* rather than by fertility industry professionals. Dr. B is rather explicit about this, arguing that egg donation "shouldn't be market-driven by ... the egg donor."

Recipients have told me, 'Oh, my egg donor's asking me for \$25,000.' I said to them, 'Do you have running shoes? Put them on, turn around, and run away. As fast as you can.' ... *The minute you let the egg donors believe that they are running a market, then they're going to try to control the market.*" (emphasis mine)

Rather than egg donors controlling the market and setting their own compensation rates, Dr. B suggests an industry-run panel determine a reasonable fee—much as the ASRM already does.

Robin, director of an egg donor program, argues similarly against allowing egg donors to set their own rates. Just as Shelby thought it was "nuts" to pay a first-time donor \$25,000 for her ova, Robin thinks it is "insane" to allow a "twenty-some-odd year-old decide how much they're worth." She, too, argues against compensation being set by what the market bears, or allowing donors to set their own rate. When asked to elaborate, she explained that market-driven compensation opens up vulnerable intended parents to be exploited by "the wrong kind of donors. I think it attracts donors who are just in it for, 'This is a great way of screwing a vulnerable person.' And, that's not right." Unlike Dr. O and Tammy, who worried about the possibility of egg donors being coerced, others, like Robin, were more sympathetic to the situation of the intended parents. For some, this may have been a function of their own experiences with infertility and uses of third party reproduction leading them to identify and empathize with the intended parents, but it would be remiss not to keep in mind that it is the intended parents, and not egg donors and surrogates, who they ultimately bill for their services.

The ASRM attempts to control the market for egg donation, but it currently offers no guidelines on caps for surrogates. Thus surrogates, according to Rebekah, already do, in effect, control the market by communicating with one another through Internet message boards. She and her business partner Shelby described for me an online world in which surrogates talk amongst themselves about how much they are getting paid for base fees as well as negotiations for monthly allowances, maternity clothes, and extra monies for C-sections. If word gets out that someone has raised their rates, “they all start talking, and the lawyers start negotiating.” As a market-driven practice, surrogates are also open to competition from other surrogates. When a surrogate demands \$50,000, but the going rate is currently about \$24,000, Rebekah explains that she tells the surrogate: “You are *so* entitled to that amount of money. But let me tell you. There is somebody else that will do this for \$22,000. And ... if I were the intended parent, why would I choose you over somebody who’d do it for half the price? It’s not that you don’t deserve it, it’s just it’s not the market value.”

Caps on compensation for egg donation, according to the ASRM, exist to reduce the coercive potential of exorbitant fees and to act as a check against the commercialization of human body parts. Curiously, there are currently no industry-driven caps on surrogacy—despite the fact that the medical and legal risks are exponentially higher. It is not clear *why* the fertility industry seems to be more comfortable with market-driven rates for surrogates than they are for egg donors, but a possible explanation may simply be supply and demand: there is already such a small number of women capable of and willing to gestate a baby for forty weeks that trying to set compensation rates may constrict the market even further. Other possible factors may include the fact that egg donors tend to be single young women in their twenties whereas surrogates tend to be married mothers in their thirties and forties, the advocacy of lawyers who negotiate contracts

for surrogates (which is less common for egg donors), or just that the sheer difference in time, labor, and risk between egg donation and surrogacy makes intended parents and brokers more willing to negotiate on price.

Regardless, the lack of caps on compensation rates for surrogacy diminishes the validity of the ethical justifications made by the ASRM for caps on egg donors. Capping compensation for egg donors appears to be more about attempts by the fertility industry to maintain control over their market position and reduce the bargaining power of donors (and the agencies that recruit them) than it is about reducing the potential for coercion or the commercialization of the human body. Egg donation in the United States is not free market capitalism in which prices are determined by the market, but industry-wide price-setting. These dynamics may be more explicit and crass when they involve the bodies of poor women in the Third World (e.g. A. Banerjee 2010), but even when the lines of flight are from China to the United States rather than from France to India, similar sets of ethical questions must be raised. Thus the United States and a handful of other nations stand alone as places where it is deemed ethically okay for women to be paid tens of thousands of dollars to sell their ova or gestate and give birth to a child with whom they will have no legal or social relationship. That the ASRM guidelines are not legally binding is moot, given that the ASRM requires the egg donor agencies they list on their website to sign an agreement that they will comply with ASRM guidelines (American Society for Reproductive Medicine (ASRM) 2011).

Embryo Transfer and “Octomom”

Several European countries, including Belgium, the United Kingdom, Sweden, Finland, Norway, and Denmark have adopted a policy known as eSET, or Elective Single Embryo

Transfer in order to reduce the rates of high-risk twin and other high-order multiple pregnancies (Cutting et al. 2008). Under eSET regulations, women who fit a particular set of criteria (such as being at risk of a twin or multiple pregnancy because of age and positive prognosis of conception via IVF) should have only a single embryo transferred during IVF, rather than multiple embryos. One of the early drawbacks to using IVF was its correlation with twin and high-order multiple pregnancies, which place the birth mother and fetuses at risk. These multiple pregnancies resulted not only from the propensity of some transferred embryos to split (forming identical twins), but from the successful implantation of more than one embryo after transfer to the uterus (forming fraternal twins and other multiples).

The primary logic behind transferring multiple embryos during IVF was—and remains—that not all embryos that are transferred into a woman’s womb are necessarily viable, and therefore transferring more than one embryo increases the chances that at least one will “take” and result in a pregnancy. Historically, this has not been the only reason for multiple embryo transfers, however. Another factor—within the United States, at least—is an unintended consequence of the CDC’s 1992 Fertility Clinic Success Rate and Certification Act, which required fertility clinics to keep track of and report statistics. I attended a debate between a bioethicist and a prominent fertility doctor at a conference organized by a national non-profit advocacy group for people wanting to have children through assisted fertility and adoption. During the question and answer period, the founder and president of this advocacy group, surrounded by several members, stood up and passionately spoke out against the repercussions of the 1992 Act because, in her opinion, it may have been intended to protect consumers, but the end result was more harm. Because consumers could now search a database to identify how successful clinics were in terms of pregnancy and birth rates, there was a push from within

clinics to boost these rates, and thus it was in clinics' interests to transfer multiple embryos to increase the likelihood of pregnancy (Rogers 2010; Schieve and Reynolds 2004). This claim about physicians being incentivized to boost statistics was also backed up by Anne. At her surrogacy agency, they advocate for single embryo transfer, since the goal is "a happy, healthy baby. Not babies born a month early. Not babies because this doctor was so anxious to achieve a pregnancy, he put in too many embryos." Anne is angry that physicians can report multiple pregnancies as "successes" without having to deal with the problems that arise, such as high medical bills or developmental delays resulting from premature births.

A third factor is on the demand side of the equation. Because IVF is quite expensive, consumers themselves may be willing to risk a twin or high-order multiple pregnancy by having more than one embryo transferred, in order to increase the likelihood of a pregnancy during the first round or rounds of IVF. As family attorney Michael (himself a father through IVF, surrogacy and egg donation), stated in my interview with him: "When you're spending thousands of dollars, ... you're like, 'I'll be damned if I'm going to risk it and then wait and send some embryos for later. ... Let's transfer three and we'll hope that we'll get one, or two.' So there's this sort of motivation, because of the insurance and the cost, to go for it."

This problem is exacerbated for international patients, who have distance, in addition to costs, to contend with. As Dr. H elaborates, he and his colleagues may transfer more than one embryo to patients who have traveled so far for services. If they lived nearby, he might advocate putting in one embryo, and having them come back the next month to try again if it does not work the first time. But this does not make sense for his international patients: "It's a lot harder to tell someone to fly from Australia every month for four months so you can have the one [embryo transfer]." Many of the providers I interviewed support the move towards reducing the

rate of high-order multiple pregnancies by transferring fewer—or even single—embryos during IVF, and even urge their patients against multiple embryo transfer. Unfortunately, this may not align with the desires of their patients, who are anxious to conceive and may be willing to take the risk.

Although the CDC has yet to enact regulations regarding embryo transfer, or to change the nature of statistics reporting to reflect the high rates of multiple pregnancies, the ASRM does offer guidance on this matter—perhaps to offset calls for the United States to adopt eSET policies similar to that of European countries. The Practice Committees of ASRM and SART (2009) argue that there must be flexibility in the number of embryos that may be transferred, in order to individualize treatment plans. Their recommendations are similar to that of eSET policies, in that criteria weighing the woman’s age and prognosis determine how many embryos should be transferred, with the recommendations erring on the side of caution to minimize high-order multiple pregnancies. Unlike eSET policies, however, the ASRM recommendations lack the teeth of law.

Not all providers I interviewed were supportive of the international move towards single embryo transfer. One of them, Dr. G in New York, derisively calls it “ridiculous” and an “international obsession” that “every regulatory authority is jumping on.” In his view, eSET does not make statistical sense, can raise rather than decrease cost, and reduce pregnancy rates. Dr. H is similarly wary of government regulating embryo transfer because for him, this would constitute the legislature being “in the business of practicing medicine. . . . When you start saying you know how many embryos to put back, you’re practicing medicine, and they’re not prepared to do that. I mean, they’re not trained to do that.” Even Anne, who advocates single embryo transfer for her surrogates, would rather that “experts,” and not politicians, create these policies.

Looming like a specter in the background of these conversations about embryo transfer was a scandal that had rocked the fertility world (and the tabloid news circuit) only a few months before I began my interviews: On January 6, 2009, Nadya Suleman (dubbed “Octomom” by the media) gave birth to octuplets as a result of multiple embryo transfer during an IVF procedure (Archibold 2009). Reports appeared over a year later (after my interviews had concluded) that her physician, Dr. Michael Kamrava, had actually transferred *twelve* embryos (Associated Press 2010). That Suleman was only 33 years old, and had already successfully given birth to six children through previous IVF treatments, means that she was probably *not* a good candidate for having more than one or two embryos transferred. Had she resided in Sweden or the United Kingdom, law would have required only a single embryo transfer; and, while ASRM guidelines would have advised against transferring more than two embryos at a time, the transfer of twelve embryos was certainly not *illegal* in this country. That is, Suleman’s doctor may have gone against professional protocol, but he did not break any laws.

Although this might have been a freakish case perfectly enacted for our reality-television obsessed world, the Suleman scandal illustrates the problem of “renegade doctors” (as Robin, one of my subjects, put it), flouting the standards of medical practice. Is self-regulation by the industry enough to ensure that physicians act in the best interest of their patients? As Dr. G phrased it, “You don’t go to jail if you didn’t follow guidelines.” When I interviewed providers in the summer of 2009, Dr. Oamrava had yet to be brought before the California Medical Board. I was curious about what providers believed were the consequences for medical professionals who go against practice guidelines—not only Dr. Oamrava, but of any physician who flouts the conventions of his profession.

Dr. B in New York seemed unsure about any consequences for doctors who do not follow

industry guidelines: “To be a member in good standing, you’ve got to conform to a certain kind of conduct. It’s not just, you don’t just send your check and do what you want to do. They could kick you out. Reprimand you. I don’t know—that’s a good question. I mean, this is America (*laughs*).” Robin wants more serious repercussions for “unscrupulous doctors.” She is aware of doctors who have injured egg donors, but are still “happily practicing.” When I asked what the consequences should be, Robin replied that they should lose their medical license. This feeling that the existing guidelines regarding embryo transfer and other protocols lack “meat and bones” (as Michael put it), was iterated by many providers.

Yet, again, as with rules about compensation for donors and surrogates, several providers are cynical about the enforcement of industry guidelines, but still wary of government intervention. Dr. H would rather that renegades such as Dr. Oamrava be dealt with internally:

The guy that made octuplets, the Octomom guy—people said, “Oh we gotta have rules, we gotta set rules. Fact of the matter is, there is a way to deal with this guy, and it’s going to come from the medical board. ... And the medical board will convene a team, ... to say, “Is this guy practicing outside the norm?” And we would all say yes, you don’t transfer eight embryos into a woman 32 years of age. ... There are rules already in place to deal with that.

Moreover, he disagrees with those who use Octomom as an example of why government standards for embryo transfer should be established. Rather than protect people, he believes that it would be especially harmful for those for whom conceiving is most difficult, guaranteeing that “they’ll never get pregnant—ever, probably.”

Providers may have expressed outrage at Dr. Oamrava—and at Suleman herself—yet this did not push them to demand more regulation of embryo transfer. Shelby, for example, stated that “Something needs to be done. I don’t want to see more Octomoms. That’s outrageous to me. It’s outrageous,” but this does not lead her to conclude that limits should be placed on embryo transfer. Those sorts of limits would amount to what she calls “extreme right-wing regulation.”

Although most of the providers (with a few exceptions) that I interviewed viewed the actions of Dr. Oamrava as unethical, and demanded that he face repercussions such as being kicked out of ASRM and losing his medical license, very few used this case as grist for more regulation. Rather, most of them—even those who were cynical about how robustly industry standards are actually followed and enforced—circled the wagons even more closely, wanting to defend their business from outside scrutiny and deal with such problems internally. Octomom seemed to have hardened their belief that the government should not be in the business of regulating the fertility industry.

From the vantage point of European nations with eSET standards, the Octomom case might offer proof that more governmental intervention and regulation is necessary, yet from the vantage point of American providers, even such an extreme flouting of medical standards is not enough to sway them from the ideology of professional autonomy and self-regulation. One set of ethics uses legislation and governmental decrees to protect women and fetuses from the risk of high-order multiple pregnancies, while the other set of ethics uses industry standards to protect the rights of doctors to practice medicine, *and* the rights of individual patient-consumers to get the type of care they desire. The American set of ethics can be summed up by a particular interpretation of *choice* and *liberty* that holds the individual's right to make decisions about how they conduct business, how they may spend their money, and what they can do with their bodies, as sacrosanct.

The latter idea was expressed by Liam, CEO of a gay-focused surrogacy agency, who was horrified by the Octomom case, but still supported Nadya Suleman's right to choose to have so many embryos transferred, and also to choose not to selectively reduce when she became pregnant with eight of them. He brought up the "fine line" and "slippery slope" argument, asking

“Is it the government’s role to come in and tell people how they should reproduce, or not reproduce?” The question has personal resonance for him, as a gay man who fathered a child through surrogacy and egg donation, in a world where gay men and lesbians are often denied the right to form families. And, as an American fertility industry professional who facilitates family formation for those living in countries where it is illegal for them to do so, he clearly has an answer to his own question.

Sex Selection and Genetic Screening

Sex selection is one of the most ethically tendentious of reproductive technologies. Although no method is 100% foolproof, there are several procedures that can dramatically increase one’s odds of having a baby of the sex of one’s choosing, including prenatal testing with selective termination, pre-implantation genetic diagnosis (PGD), and sperm sorting. Sexism, gender discrimination, and patriarchy form the backdrop to much sex selection throughout the world, where the tendency is to select *for* boys and *against* girls, leading to skewed gender ratios in countries such as China, Korea, and India (Sen 2003; UNFPA 2007). Desiring boy children for patriarchal reasons is not the only rationale behind sex selection, however. Another reason is so-called “gender balancing,” in which intended parents with, say, three boys want their fourth child to be a girl. Finally, sex selection is used for medical reasons, wherein people who want to have biological children but who are carriers for sex-linked (or X-linked recessive) genetic diseases, such as hemophilia or fragile-X syndrome, select for girl children only. Because girls have two X chromosomes, they are far less likely to be affected by such a disorder than boys, who, lacking another X chromosome, typically have a 25% chance of having the disease (WHO Genomic resource centre 2011).

Several countries outright ban all forms of sex selection, for any purpose, including Austria, New Zealand, South Korea, Switzerland, and Vietnam. There are far more countries that ban any “social” uses of sex selection; that is, they allow sex selection only for medical reasons, as in the final scenario described in the above paragraph. The BioPolicyWiki cites 31 countries, on every continent, that prohibit social uses of sex selection, including Germany, France, China, Japan, the United Kingdom, Israel, Italy, Spain, Singapore, and Australia, and most other OECD nations (BioPolicyWiki 2009).

Laws against sex selection do not, however, stifle demand for the practice, but rather shifts the market to more favorable legal climates. The United States, as one of the few countries that does not prohibit any form of sex selection and also has a thriving fertility industry capable of conducting PGD and IVF, is thus an international destination for those seeking sex selection services. Several of the clinics where I conducted interviews, in fact, cited sex selection as one of the primary reasons that they received inquiries from international clients. A physician at a Los Angeles clinic, for example, told me that about 60% of his clients were from overseas, and the majority of them were coming to him precisely for sex selection (“Almost everybody coming in—80% of them are coming in for gender selection. It’s illegal everywhere, it’s legal here, they come in”).¹⁵

Despite the legality of sex selection in the United States, professionals maintain the right to determine whether or not they will provide the service. At the New York clinic where Liz coordinates an egg donor program, the ethics committee decided not to use IVF for sex selection in a case where there was no other medical indication for this treatment. They saw the required surgery as too big of a risk that could compromise the woman’s fertility and even her life. Liz

¹⁵ The rest of his international clients, he claims, come for surrogacy—also a practice illegal in many of their home countries.

minimizes the desire of patients who come to her for IVF solely for gender balancing purposes: “The answer was no.”

Ironically, some of the providers I interviewed had themselves used sex selection when they had their own children, yet were dubious about other people choosing the sex of their babies. Anne, for example, claimed that she did not work with couples from the Middle East because of their gender bias against women. “They want males. Not that that’s not okay. I did sex selection to have my son, after we had a girl. But they want only males. And they don’t seem to have any issue with killing a female just because it’s a female. So we said ‘No, we don’t really need to help these people have babies.’” Thus although she makes many “feminist” claims about the individual’s right to obtain the services they desire, and to have ownership over their own bodies, her sense of individualism also extends to the provider’s right to turn down potential clients on the basis of personal ethics (or, indeed, prejudice).

Besides sex, genetic screening can also be used to screen for genetic traits, and this is another area where international policy varies widely. A similar set of fears and circumstances surround this practice: should intended parents have the right to decide what type of baby they want to have? Although PGD is largely used to reduce the risk of parents passing down genetic diseases to their offspring, it may also be used to screen *for* traits. For example, a number of providers spoke of cases where deaf couples wanted to use PGD to select only those embryos that carried a genetic trait for deafness. Again, policies vary in terms of how the bans are carried out. Some, like Germany, Austria, Lithuania, and Switzerland ban *all* uses of PGD. Many others ban it only for “social” reasons (including non-medical sex selection).

Even without any regulations against the uses of PGD within the United States, outside forces help determine the types of services that clinics offer. Dr. S, the Los Angeles doctor who

receives such large numbers of patients wanting sex selection, told me that his clinic had developed the technology to determine eye and hair color. However, after releasing this information to the media, “The world went berserk. My publicist in New York called me up and said, ‘Doctor, the pope’s talking about you.’ ... So we said, okay, the world’s not ready for this, and we just withdrew it. A huge media thing, designer babies. ... Okay, fine, forget it.”

Shelby and Rebekah also received backlash for helping to facilitate an unusual case of PGD and surrogacy: a couple had a sick child, and wanted to have another child to act as a bone marrow donor. The child had to be a full sibling, and the couple was fortunate enough to have frozen embryos left over from previous rounds of IVF. This couple sought the help of Shelby and Rebekah to find them a surrogate willing to carry this donor child. After advertising for a surrogate, they received angry letters from people that called them “sick” and told them they should be ashamed of themselves. Rebekah was somewhat baffled by the negative response: “I was like, ‘What is wrong with this?’ ... It’s a child that’s going to be loved. It’s not discarded, it’s not brought in and used for its parts. It’s not harvesting organs. It’s a person! And it’s going to be loved.”

FERTILITY PROFESSIONALS AS MORAL GATEKEEPERS

“The government, when it gets involved, establishes its own standards without consulting with us, and we don’t have much influence over the policies that have been put in place. And, that’s not good. ... That sort of stuff is much better evolved within the system, within a group of people who know what they’re doing, and want a high quality standard. So, regulation is what governments do, but I wish they did a better job of it. I wish they would just talk to us!” – Dr. C

As the providers continually reiterated to me, ethics are deeply embedded within their daily practice, and they take them seriously. Although the fertility industry in the United States is much less regulated than many other nations, the providers do not take this to mean that this

country is less ethical; rather, they believe that we organize our ethics differently here. The United Kingdom or Japan or Australia may find it good government to legislate morality—creating boundaries around what types of technologies and procedures may be offered, and to what types of people—but most of the people I interviewed are uncomfortable with the United States government taking a similar tack. It is not that the providers believe that no boundaries should be set on how physicians practice, but they largely believe that these boundaries should be established by the physicians—and other fertility industry members—themselves.

Another way to consider this is that fertility industry professionals act, whether consciously or not, as moral gatekeepers. Over and over again, they told me that individuals have the right to make their own choices when it comes to procreative decision-making. Yet they also expressed discomfort about clients who pushed them to do things they did not find medically necessary or who wanted assisted fertility services for the “wrong” reasons. When asked if they, as providers, have the right to turn down clients who want to do something they do not agree with—for medical or ethical reasons—they responded in the affirmative. Personal autonomy gets translated into *professional* autonomy (Freidson 1988). For example, Dr. H answered that it is a “given” that patients are responsible for deciding what is ethically right or wrong or morally permissible, but then immediately followed this statement with a reiteration of ethical principles from the standpoint of medical practitioners rather than of patients. In a discussion about the appropriateness of fertility services for intended parents of advanced maternal or paternal age, he reinforces the point that rather than let a 68 year old woman who wants to have a baby do whatever she wants, physicians can use their ethical principles to guide their judgment.

The appropriate age of intended parents was a point that several providers brought up, perhaps because of the recent revelation that the oldest woman to have ever become a mother

had just died, less than three years after bearing twins at the age of 66. Maria Carmen Bousada, a single Spanish woman, had traveled to Los Angeles for treatment, and lied to the fertility clinic about her age (Tremlett and Walker 2009).¹⁶ The providers regaled me with a number of stories about clients they felt morally obligated to turn away, including a man who wanted to contract with three surrogates who would each simultaneously carry triplets (for his own baseball team!), celebrities who did not want to gestate their own children in order to maintain their slim figures, and a couple in which one of the partners had AIDS.

Rather than turning away clients out of ethical concerns, most providers tend to steer their clients towards choices they feel are more appropriate. Both Dr. M, a physician at a New York clinic, and Linda, Operations Director of a Los Angeles clinic, used sex selection as examples of how they “guide” the patient towards more ethical decisions. As Dr. M stated:

If the patient comes in and says, ‘I’m interested in doing PGD because I want a boy and I have three girls already,’ well, as a physician, you have to explain to the patient what are the cons of doing that. And you have to guide the patient... in terms of what’s right, what’s wrong, and again, the patient has the right to choose what she wants to do or not.

Linda is more blunt with clients about her disdain for sex selection for non-medical reasons:

I’m sorry, you know, you don’t need PGD. PGD is meant for testing for genetic issues that might come up for your ultimate goal, which is to have a baby. ... It doesn’t matter if it’s a boy or a girl. ... I have very strong issues with that.

She, like Dr. M, tries to guide her clients to what she sees as a more moral decision. She describes an incident that occurred the day before, in which a couple had come in and the husband began to inquire about selecting for sex. “And I just blurted—usually I don’t do that—I said, ‘You don’t even want to go there. You’ll be lucky to have one biological healthy child, and that should be your goal right now.’”

Personal and professional ethics do not only apply to intended parents. Fertility industry

¹⁶ One of the providers I interviewed, who personally knows the doctor who treated Bousada, said that he was just “devastated” when he found out how old she really was.

providers also create rules that apply to donors and surrogates out of concern for their physical and psychological health. Anne states that her agency puts a limit on how many times a woman may work with them as a surrogate, because “They’re not machines. This isn’t what they do for a living.” Several agencies and clinics stated that egg donors may donate for no more than six cycles, and get angry when they find out that some donors have lied to them about previous donations at other agencies. They also have elaborate screening processes that may go beyond industry standards, turning away donors who have histories of alcoholism or depression, for example.

Moreover, no one spoke of wanting to practice in a field that is just a free-for-all, where patients can get any type of services they want for any reason, or where providers act entirely on their own in decision-making; many spoke appreciatively of being able to consult with their colleagues (or with ethics committees, if their organizations had them) for help with tough ethical decisions. For the most part, providers told me that they appreciate the guidelines provided by their professional organizations, and want there to be consequences when colleagues break the norms of their profession. Overall, many would like the benefits of policies developed by their *peers* without the interference of regulation developed by *lawmakers*. That is, the majority of the people I spoke with promote self-regulation, but not on the individual level; rather, they prefer regulation of the industry by the industry itself.

In *Deviance and Medicalization*, Conrad and Schneider (1992) describe how physicians, in their quest to be the sole designators of definitions and treatment of what they see as “illness,” act as “moral entrepreneurs” (23). Fertility industry professionals, in their quest to keep ethical debates and regulation of professional norms *within the industry itself*, with especial respect to the expert knowledge and authority of physicians, illustrate this moral entrepreneurship quite

nicely. The ethic of professional autonomy is useful in the quest to maintain dominance over the field of procreation, elbowing out both political and religious authorities.

Self-regulation is a means for physicians and other professionals to maintain their authority and dominance over professional knowledge and practice. Physicians and attorneys both have codes of professional ethics, but even those providers who serve more of a mediating or brokering role at egg donor and surrogacy agencies are able to latch onto or defer to the moral prestige and authority of their counterparts in the medical and legal professions. Providers do not want politicians to be moral gatekeepers, nor do they trust ethical norms to be led by religious adherents or the whims of society. It is physicians—and sometimes attorneys and other professionals—who are held up as the rational experts who can best negotiate the ethics of reproductive technologies.

Physicians within the United States have been gradually losing some of their authority over the past few decades (A. E. Clarke et al. 2003, 2010; Conrad 2007; Light 2009; McKinlay and Marceau 2009). They have become “proletarianized” as they have become employees of hospital corporations, burdened by HMOs that interfere with their medical decision-making, and must contend with the informed consumer who might question their medical expertise with their own knowledge gleaned from the Internet, self-help groups, and direct-to-consumer advertising. However, because much fertility treatment is still largely seen as elective, luxury, or boutique medicine, several of these transformations of modern medicine do not apply to fertility doctors as severely as they do to, say internists. Those fertility doctors associated with medical schools, for example, can reap huge salaries as some of the highest-paid faculty members.¹⁷ Others work privately at their own clinics, hewing to the earlier model of the physician as small business-

¹⁷ As the *New York Times* reported, among the highest paid faculty at Cornell and New York University, earning \$3,149,376 and \$2,393,646 respectively, are renowned fertility doctors Zev Rosenwaks and James Grifo (Lewin 2009).

owner. Fertility clinics may get overwhelmed by the paperwork required by health insurance and maintenance organizations, but given that there is such high demand for their services, many consumers are willing to pay out of pocket for uncovered services; that is to say, the high incomes of many of their clients means that they are perhaps not as constricted by Byzantine insurance requirements as doctors in other fields. For those with large numbers of clients from abroad, they do not have to deal with insurance companies at all.

As far as the transformation of the patient into the discerning consumer, the entire thrust of this project bears out this detail: when consumers cannot get the medical services they want in their home countries—because they are too expensive, prohibited, or any other reason—they may be empowered to search the Internet and query acquaintances in order to find these services elsewhere. The American fertility industry gains clients in this manner, but it also loses them for the same reason: when providers turn down a client’s request for treatment, that client retains the option to find someone who will fulfill their desire. This, again, occurs partially as a result of the ambiguous role of the patient as consumer, wherein a tension exists between two clichés: “Doctors Know Best” and “The Customer Is Always Right.”

Thus, a benefit of allowing the industry to regulate itself—left unsaid by my participants, I should note—is that self-regulation is also great for business. By acting as a safe haven for intended parents around the world who are prohibited from consuming services that their home cultures find at the very least ethically troubling, if not morally repugnant, the United States fertility industry increases its *global* market share, all the while paying lip service to the *national* ideals of freedom, rights, liberty, and personal (and professional) autonomy. These national ideals—contrasted with the alternative ethics that emphasize the collective good—are employed rather nicely as a “competitive advantage” in the global fertility marketplace.

CONCLUSION: REPRODUCTIVE AUTONOMY?

“You know, ... it’s really not even a medical discussion. It’s really a philosophical, political discussion, rather than a medical discussion. ... We here in the United States have a lot of tolerance for individual rights. Our European colleagues have much less.” –Dr. G

Providers’ animosity towards governmental regulation points to their discomfort with ethics—particularly, what they view as *medical* ethics—being politically determined. While they do not espouse a strict libertarian ethos heralding the supreme right of the individual, the collective narrative that emerges from my interviews aligns with a liberal interpretation of medicine and the family as private, self-enclosed spheres that should be shielded by the vagaries of government, religion, and other social institutions. The call from doctors to be able to practice medicine the way they want to merges with the call from intended parents to form families the way they want to. This liberal interpretation of medicine and family is not dissimilar to how the Supreme Court decisions of *Griswold* and *Roe* were determined on the basis of the sanctity of the physician-patient relationship *and* the privacy of the family, and not on the basis of reproductive justice or bodily autonomy, however much those may have been consequences (Petchesky 1990).

The concept of bodily autonomy, in turn, has become conflated with the notion of reproductive autonomy. That is, we tend to see the right to self-determination over procreative decision-making as a subset of the right to self-determination over one’s body. This is surely the case when it comes to contraception, abortion, and even many forms of fertility treatment. It is *not* as clear, however, that this is the kind of reproductive autonomy championed by the fertility industry. I have already analyzed how providers place greater emphasis on *professional* autonomy—that is, the right to do their jobs with minimal governmental or societal interference—than on the right of the client to obtain any kind of care they need or desire. Yet

they are not unsympathetic to the wishes and desires of intended parents; they frame themselves as professionals who enable intended parents throughout the world to have the children of their dreams, in the face of overt governmental policies that tell them that they *do not have this right* or that *it is ethically wrong*. In this respect they are champions of a different form of reproductive autonomy that emphasizes not only the right to do with one's body as one wishes, but to the right to procreate and build families in the way that one chooses.

This form of reproductive autonomy may include variants of the other form of reproductive autonomy, in that technologically-mediated procreation often involves the manipulation of one's own body. But when third parties are involved—sperm donors, egg donors, and surrogates—is this not a corruption of the very notion of “autonomy,” with its implication of self-directedness? Can one person's reproductive autonomy be premised on the manipulation of someone else's body?¹⁸

The right of egg donors, sperm donors, and surrogates to sell their reproductive labor and their bodily resources, can, however, also be framed as a matter of bodily autonomy. The premise for the legality of surrogacy within the United States (albeit not in all fifty states), for example, is that women should retain the right of self-determination to do with their bodies as they wish. But, just as American feminists have historically been divided over whether sex work is a display of autonomy or merely exploitation, so too do arguments fly between feminists about the relative autonomy of women who choose to become surrogates. This split between championing women's bodily autonomy and protecting women against the corruption of bodily integrity is exemplified by the different directions that New York State and California have taken in regard to surrogacy: commercial surrogacy is de facto illegal in New York, in that the state

¹⁸ See, for example, the recent *New York Times Magazine* article written by a woman who contracted with an egg donor and two surrogates so that she and her husband could have twins (Thernstrom 2010).

will not recognize contracts made between surrogates and intended parents, whereas California's laws have made that state a haven for surrogacy practice (Markens 2007).

This intranational split between New York and California is instructive. Although national policies regarding the body, population, sexuality, and reproduction may be attempted by elected officials and technocrats to translate *collective ethics* into law—a neat illustration of Foucault's concept of “governmentality”—this does not erase conflicts between sub-national regions, in which case the very notion of “collective ethics” may begin to break down into smaller and smaller units. Governmental bodies are not the only type of “collectives,” either. As I described in this chapter, other stakeholders may have their own set of ethics that align or conflict with policy. In this project I emphasize the fertility industry as one stakeholder (which can, in turn, be broken down into even more collective units, including physicians, attorneys, egg donor and surrogacy brokers, and so on), but we may also include: intended parents, third party donors and surrogates, the offspring of assisted reproductive technologies, religious institutions, reproductive rights organizations, bioethicists, among a host of other interested parties.

And yet, even though fertility industry professionals are aware that different regions within the United States have different laws and policies, that some conservative and religious groups, for example, disapprove of their meddling with the creation of human life, and that, on a micro level, each individual brings to the table his or her own personal set of ethics, I did get a sense from these fertility industry professionals a belief that there is something particularly “American” about how the fertility industry operates here. This ethic is rooted in those classical liberal tropes of autonomy, liberty, and choice. Dr. G, who I cited at the beginning of this chapter for articulating a difference between “American” and “European” ethics, sheds more light on what he sees as the emphasis on the individual over the collective:

I think in principle, at least here in America, we believe that we have a right to decide how we want to live our lives, how we want to create our families ... We are ... coming from a tradition of self-determination ... And some of our strongest clashes, especially in our specialty meetings with European colleagues ... have been on that subject, because they are much more driven by what they perceive to be good for everybody. ... We here in the United States have a lot of tolerance for individual rights. Our European colleagues have much less.

Such language articulates a belief in the righteousness of individual rights over the collective, and frames the American fertility industry professional as one who enables his clients—even non-Americans—from assuming these rights. Imagining a unique set of ethics with the autonomous, rights-bearing individual at its apex fits neatly into narratives of American exceptionalism and moral righteousness.

Chapter Five

The Genetic Imperative: Compulsory Motherhood Meets the New Eugenics

Genetic thinking permeates our lives. Stories involving genetics abound in the mainstream press; we are continually confronted with reports about controversies or breakthroughs around cloning, stem cell research, animal-human hybrids, “designer babies,” breast cancer genes, or yet another man on death row freed after DNA testing proves his innocence. Reilly (2006), Nelkin and Lindee (1995), and Rothman (2001), among others, have each published important monographs marking some of the ways in which genes, genetic research, and genetic thinking have transformed many aspects of our lives, including what it means to be human.

Moreover, the above authors point to the relationship, however tentative, between nineteenth and twentieth century eugenics and more recent strands of genetic determinism. The term eugenics may evoke compulsory sterilization laws and population control programs, Hitler’s genocidal Nazi regime, marriage laws, and the institutionalization of people with physical and mental disabilities, all of which aimed to limit or eliminate a person or an entire people’s reproductive capacities based on a metric of “fitness.” Yet if eugenics is a practice of socially engineering populations through policy and technology in order to propagate good genes and eliminate bad genetic strains, we must keep in mind that *positive* eugenic practices were just as widespread as the *negative* eugenic ones named above. At the same time poor and institutionalized women in the 1920s and 1930s were being sterilized in order to prevent them from having children, affluent white women were being targeted with propaganda urging them to procreate (Gordon 1976; Haller 1963; Kevles 1995). As a technique of *bio-power*, the function

of eugenics in the late nineteenth and early twentieth centuries was not merely social engineering, but also discipline and regulation of the individual and social body (Foucault 1978).

In the first decades of the twentieth century, policymakers, social workers, birth control advocates, and other eugenicists lamented the number of babies being born to poor, immigrant, and non-white women. Affluent white women, in turn, were accused of committing “race suicide” by practicing birth control and limiting the numbers of children they bore; the fate of the American population rested in their wombs (Gordon 1976). Although one may seem more benign than the other, both positive and negative eugenics are grounded in the same ideology that labels some members of the population worthy of reproduction, and others worthy of elimination; they are two sides of the same coin, shaping such modern-day practices as sperm banking (Moore 2007) and genetic testing (Duster 2003; Rothschild 2005).

Eugenics exemplifies a convergence of science, technology, race, and sexuality through embodied practices. The popularity and most repressive tactics of eugenics faded in the wake of World War II and developments in the social and biological sciences, but eugenics has never really left us; rather it has manifested in new and subtler forms. In Troy Duster’s (2003) terminology, eugenics now enters through the back door. Contemporary debates about genetic screening, euthanasia, disability rights, and welfare reform may point us towards the ways that fears of a eugenic reprisal linger in the American—and German, as Habermas (2003) reminds us—consciousness.

Affluent and middle-class women at the turn of the twenty-first century are sometimes accused of being selfish for putting their careers first and delaying childbirth. Yet what science has contributed to our modern-day Cult of True Womanhood is the ability for motherhood to transcend the limits of biology and the aging body: through the wonders of reproductive

technology, a woman can rise in the ranks of her profession and still be able to experience the (medical) miracle of childbirth. As Angela Davis (1993) writes, “the new reproductive medicine sends out a message to those who are capable of receiving it: motherhood lies just beyond the next technology. The consequence is an ideological compulsion toward a palpable goal: a child one creates either via one’s own reproductive activity or via someone else’s” (360). Many reproductive technologies are linked to this power to facilitate the birth of children to certain classes of women—and thus its arguable linkage with new forms of positive eugenics. See for example the recent string of *New York Times Magazine* first-person narratives written by upper- and upper-middle-class white women relying on costly IVF and third party reproduction in their struggles against infertility (Kuczynski 2008; Orenstein 2007; Thernstrom 2010).

In many respects, reproductive technologies are seemingly innocuous practices that help the infertile to have children, with no concrete relationship to last century’s state-sanctioned eugenics movement involving large populations. They are a market-oriented transaction between donor and consumer, mediated not by the state, but by private agencies and medical clinics, in order to facilitate the birth of individual children, what Barbara Katz Rothman (2001) calls “microeugenics.” These differences notwithstanding, we can trace a lingering ideological and discursive thread from twentieth century eugenic practices to twenty-first century forms of reproductive and genetic technologies. This lingering thread is *heritability*, which attempts to account for the variance within a given population by inherited genetic traits (Duster 2003; Kevles 1995). In decades past, traits such as intelligence, promiscuity, poverty, and criminality were believed to be heritable qualities passed down through one’s genes; this belief was linked with biological determinism and the idea that biology is destiny. The ideological backdrop of biological determinism and Social Darwinism served to justify the sterilization and

institutionalization of tens of thousands of people in the United States—and the mass murder of millions in Europe—in the first half of the twentieth century. If heritability of traits was the theory, eugenics was the practice.

Theories of biological determinism did not disappear with the demise of the popular eugenics movement; rather, they have continued to flourish in new ways conjoined with advances in science and technology. It is through technology, some would argue, that we can finally wrest destiny out of the hands of biology. New projects in the fields of science and medicine have similar—though less sinister—goals as did eugenic programs from the previous century; scientists aim to learn what our genes have to tell us, and with that knowledge, to gain the power over our destiny and over life itself. Thus when scientists begin mapping the human genome, or doctors screen fetuses for genetic defects, or fertility clinics advertise the stellar qualities of their egg donors, implicit in these practices is the idea that our genetic material is ripe with useful and identifiable knowledge that can be manipulated to alter and improve us.

Donna Haraway (1997) identifies a “gene fetishism” within contemporary bioscience and biotechnology, wherein the gene is valued as a thing in and of itself, separate from the body and its processes (141-8). We do not have to take too far a leap to see how easily a woman’s ova—bundles of genetic material in themselves—can become fetishized and commodified. And the value of her eggs may be explicitly tied to the value of her genetic material—the “goodness” of her heritable traits. Yet how does one quantify the value of a woman’s genetic material, the fitness of her oocytes? According to the mythology of heritability, her ova have a story to tell about ancestral history and genetic destiny, yet we need a feasible way to decipher what those gametes are telling us. At the same time the gene is fetishized as a thing in and of itself—the part

standing in for, and apart from, the whole—it is the woman *in her totality*, a sort of reverse metonymy, that also comes to stand in for the eggs she carries.

The marketing, provision, and consumption of assisted reproductive technologies do not exist within a vacuum. Rather, practices such as surrogacy tourism, egg donation and egg freezing, and sex selection are overdetermined by a number of structural, technological, and ideological factors. These independent variables include the contemporary manifestations of global capitalism and neoliberalism, scientific advancement and innovation, the biomedicalization of reproduction, and what I refer to here as the “genetic imperative.” How does the genetic imperative contribute to, if not determine or drive, the practice of individuals who go to extraordinary financial, geographic, and technological ends to get pregnant, give birth to or take home a child? I use the example of egg donor matching to illustrate the genetic imperative in practice, and discuss it in the context of eugenics. In sum, the discussion points to ways in which issues of *patriarchy* and *race* are embedded in the genetic imperative, and made manifest in contemporary fertility industry practices (L. J. Martin 2010).

ARTICULATING THE GENETIC IMPERATIVE

By “genetic imperative” I mean both the individual drive *and* the cultural mandate to have genetically related children, to “reproduce” oneself (putting aside for the moment whether that desire is evolutionarily hard-wired or socially constructed). It is both a micro and a macro concept. Sociobiologists and evolutionary psychologists theorize a genetic imperative in which all organisms have an unconscious drive to pass on their DNA to future generations. According to disciplinary founder Edward O. Wilson (2000), the primary function of an organism “is not even to reproduce other organisms; it reproduces genes, and it serves as their temporary carrier”

(3). For humans, the desire to have children that you are genetically related to is a matter of evolutionary survival, to ensure that your distinct hereditary map is preserved, that when you die, part of you will live on, embodied in another person, there to be replicated ad infinitum in future generations. Dawkins (2006) frames this imperative in terms of “selfishness”: he describes humans and other organisms as “survival machines” who are cybernetically programmed to behave in such a manner as to “replicate” their genes. Freedman’s (1979) summation of sociobiology and selfish-gene theory is that “the motive-force of life and evolution is to pass on one’s genetic material to subsequent generations in any way possible” (Cronk and Gerkey 2007). These theorists have taken up this mantra to explain mating patterns, polygamy, and male aggression, among other patterns of human behavior (Freedman 1979).

Haraway (1991) and Lancaster (2003), among others, make thorough critiques of evolutionary psychology and sociobiological theories, pointing out the fallacies in logic and the lack of attention paid to how patterns of human behavior—not to mention science and our understandings of nature—are socially and culturally constructed. Without entering the debate about whether a reproductive or genetic imperative is biologically driven or culturally produced, I would like to describe the genetic imperative as an ideology or, in Foucauldian terms, a *discourse*. That is, what are the social or discursive effects of this line of thinking? Who is it that is espousing it? To what ends is this discourse used? Who profits from it? Who is burdened by it? What are the power relations embedded within it? Whether or not the genetic imperative is a result of instinct, socialization, or some combination of the two, is beside the point.

From a sociological standpoint, the genetic imperative has meaningful consequences for our senses of self, the choices we make and our ideas about what is or is not possible and purposeful. As Bourdieu (1984) might put it, the genetic imperative is a “structuring structure,”

framing and molding our habits, our desires, and our actions in culturally distinct ways. For example, not being able to reproduce “naturally” is a source of stigma in many societies, including our own, that view having biologically related children as a necessary and desirable life process in the path to full adulthood. This is especially so for women. In Shulamith Firestone’s (1970) classic feminist polemic, she argues that patriarchal societies use the biological fact of women’s bodies and capacities for reproduction as a means to shackle them into roles as breeders and mothers. Adrienne Rich (1986) speaks of the moral imperatives attached to mothering, and condemns the idea that motherhood is a “sacred calling” for women (42). Both authors contribute to a wide literature on the nature of compulsory motherhood, the idea that procreation is not a choice made by each individual woman, but that it is an ideology prescribed and compelled. At the same time, given the history of eugenics, it would be impossible to state that motherhood is mandatory for *all* women; rather, one’s reproductive choices are prescribed by wider societal goals and actors. Indeed, history bears out that motherhood is only valued (or indeed compulsory) for certain classes of women, and that for some, the drive to reproduce must be stamped out or disincentivized (Collins 2000; Gordon 1976; D. E. Roberts 2009; Smith-Rosenberg 1986; Solinger 2000). Eugenics and Social Darwinism, after all, were movements that expressed fears of any innate genetic imperative that would lead people to “selfishly” reproduce themselves regardless of their contribution to the human gene pool.

Apart from the feasibility of some evolutionary drive, compulsory motherhood and the genetic imperative are culturally prescribed and reinforced by family pressures, the media, and institutional and political barriers to alternative family formation. If one is a member of a class compelled or encouraged to have biological children, but is in the situation of not being able to

reproduce via heterosexual intercourse, either because of a biomedical condition (i.e. infertility), or because of one's relationship status (i.e. single or in a same-sex relationship), then how does one fulfill that mandate? This is where assisted reproductive technologies (ART) and asexual reproduction come in. The fertility industry operates to support and uphold the genetic imperative for certain classes of people, and in the process both relieves and reinforces the stigma of childlessness and infertility.

There are numerous iterations and configurations in which the genetic imperative becomes manifest in ART. Microsurgery and fertility drugs may be offered as treatments for infertility, enabling the continuity of either the male or female line. Artificial insemination with donor sperm allows for the genetic continuity of the female line for single women, lesbian couples, and heterosexual couples with male-factor infertility. In vitro fertilization (IVF) and intra-cytoplasmic sperm injection (ICSI) may bypass either male- or female-factor infertility (or a combination of the two), enabling heterosexual couples to use their own gametes. Significantly, IVF and ICSI, which require a high degree of medical intervention on women's bodies, are often used as treatments for *male*-factor infertility, and are perhaps some of the most obvious demonstrations of the gendered nature of the genetic imperative as it relates to compulsory motherhood (Becker 2000; Franklin 1997; Thompson 2005). Passing on one's genes is of paramount importance to men, yet under patriarchy, it is women who are primarily responsible for reproduction (Rothman 2000). Whereas male-factor infertility may be "solved" via artificial insemination by donor sperm, donor sperm obviously does not fulfill the genetic imperative on the male line. If there is female-factor infertility, IVF and ICSI combined with egg donation is the functional (though not material or technological) equivalent of artificial insemination, enabling the continuity of the male line.

Finally, there are a couple iterations of surrogacy that demonstrate the genetic imperative. In AI surrogacy, a woman who is not the intended mother (i.e. the surrogate) is inseminated with the sperm of the intended father as a means to preserve the male line for single men, gay couples, or heterosexual couples with female-factor infertility. In IVF surrogacy, on the other hand, the surrogate undergoes IVF instead of insemination, and is therefore, unlike the AI surrogate, not at all genetically related to the child that she carries. The embryo that is transferred into her uterus may derive from gametes from the intended parents and/or from donors, enabling the continuity of the male or female line, if not both.

As one can see in Table 5.1, with the exception of technologies and services using both donated sperm *and* egg (either as independent gametes or as donated frozen embryos), most assisted fertility services and technologies enable intended parents to preserve at least one of their genetic lines. Obviously, when they do not use any donor gametes, both the male and female lines are preserved.

Table 5.1: The genetic imperative in assisted fertility services and technologies

Type of technology or service	Preserves male line	Preserves female line
Fertility drugs	X	X
Surgery	X	X
IVF or ICSI without gamete donation	X	X
IVF or ICSI with donor sperm		X
IVF or ICSI with donor egg	X	
IVF or ICSI with donor sperm and egg		
Artificial insemination without donor sperm	X	X
Artificial insemination with donor sperm		X
AI surrogacy	X	
IVF surrogacy without gamete donation	X	X
IVF surrogacy with donor sperm		X
IVF surrogacy with donor egg	X	

IVF surrogacy with donor sperm and egg		
Embryo donation		
Autologous sperm banking	X	
Autologous egg freezing		X

Aside from parent-to-child genetic continuity, ARTs also enable genetic relatedness between siblings. That is, people who use artificial insemination by donor sperm may decide to use the same donor for all of their children, an AI surrogate may have a succession of children for one individual or couple, and an IVF surrogate may be “implanted” with more than one embryo to induce twins or high-order multiples. Depending on her age and health status, an egg donor may be used by the same intended parent(s) more than once and, although egg freezing is not yet a reliable technology, at some point in the future we can imagine egg banking functioning in a similar way as sperm banking now does, with repeat withdrawals of the genetic material of a single donor. Embryo cryopreservation also enables genetic continuity between siblings; if there are any extra viable embryos left after an individual or couple uses IVF or ICSI (with or without donated gametes or a surrogate), these potential full siblings may be frozen and stored for future use.

As a “structuring structure,” the genetic imperative produces a normative mode of parenting that reifies the genetic relatedness between parent and child over other relations of kinship (L. J. Martin 2010). Those who are infertile, unpartnered, lesbian, or gay may be stigmatized for not being able to fulfill this genetic imperative. Prior to the widening awareness and availability of reproductive technologies, these categories of people may have experienced a legitimate “out” or “excuse” for their inability to have genetically related children without medical intervention (Mamo 2007). Today, the genetic imperative even holds for those individuals whose parenting is typically marginalized by their relationship status or sexual

orientation, such that if single people or lesbian or gay couples strive to have children, assisted reproductive technologies allow them to fulfill this goal without resorting to adoption. In this respect, we see the co-constructive relationship between reproductive technologies and the genetic imperative. Scientists and physicians have innovated reproductive technologies to enable the infertile, single people, lesbians, and gay men to have genetically-related children. The development of these technologies is in direct response to the genetic imperative and the desire/drive to continue the genetic line of at least one of the intended parents.

Once the technology exists, those who previously might have resigned themselves to childlessness or who would have become parents through other means such as adoption are now no longer absolved from the genetic imperative. The technology itself becomes prescriptive, even as it remains financially out of reach for many. This is not to be technologically determinist, but to point out how technology is both laden with and creates norms and values. The co-construction of technology and ideology problematizes norms about “natural” parenting. Although ARTs such as IVF faced much public backlash when they were initially developed and successfully implemented (Henig 2004), they have, at least in the United States, entered the public consciousness as available means of parenting and procreation, at least for those who can afford it or whose insurance covers it.¹⁹ Furthermore, if the genetic imperative—that is, the drive to have genetically-related children—is described as something “only natural,” then the use of artificial means to achieve this imperative also becomes bound up with the natural. Isn't it “only natural” that a parent would want to be genetically related to his or her offspring? What is more natural than a family with commingling DNA?

¹⁹ See for example the growing number of Hollywood movies featuring assisted reproduction, such as “Baby Mama,” “The Kids Are All Right,” and “Then She Found Me,” and the tabloid stories about celebrities who have had children through the use of surrogates.

Genetic Imperative versus the Biological Imperative

The genetic imperative—to have a genetically related child—is related to, but distinct from, the biological imperative—to have a biologically related child. Assisted reproductive technologies enable intended parents to achieve one, if not both, of these demands. The biological imperative is inherently gendered. For male intended parents, the imperatives are identical: a biological child is a genetic child. He has the same biogenetic relation to the child whether he impregnates his wife via intercourse, or has a child through artificial insemination, in vitro fertilization, or surrogacy. There is no need to make the distinction, then, between a biological father and a genetic father. It is tautological to state that a biological father is a man who contributes DNA to his offspring.

The same cannot be said for women, whose physiology affords them at least two ways to have biologically-related children: through the genetic relation and through gestation. If a woman uses IVF to have a baby using another woman's donated egg, which woman is the "biological" mother? The one who carried and gave birth to it, or the one who contributed DNA? Likewise, the same exact question can be asked if a woman uses her own fertilized egg but employs another woman to gestate it: which woman is the "biological" mother? The one who carried and gave birth to the baby, or the one who contributed DNA? With the use of reproductive technologies such as egg donation and surrogacy, the previously commonsense term "biological mother" has been rendered meaningless, replaced by the more specific terms "genetic mother" and "birth mother" (or even "gestational mother").

Semantics aside, the biological imperative is, simply, the drive or desire to have a child that is biologically-related to you. As indicated above, for men this means to have a genetically-related child, but for women, this biological imperative speaks to a relation born of DNA *or*

blood; it is about inheritance *or* nurturance. Prior to the advent of reproductive technology, there was no need to separate out these two aspects of biological relatedness. For women, to have a biological child was to nurture a child *in utero* that was implicitly “your own.” Today, women who cannot “naturally” conceive and/or gestate a child have a number of options that can enable their biological motherhood.

As Table 5.1 indicated, depending on the type of NRT that is utilized, the nature of the mother’s genetic connection to the child will vary. Alternatively, Table 2 indicates the varying kinds of “biological” connectedness of these NRTs:

Table 5.2: Mothers’ Biological Relatedness

Type of technology or service	Enables biological connection of intended mother	Enables genetic relatedness of intended mother	Enables gestation/nurturing by intended mother
Fertility drugs	X	X	X
Surgery	X	X	X
IVF or ICSI using own gametes	X	X	X
IVF or ICSI with donor sperm	X	X	X
IVF or ICSI with donor egg	X		X
IVF or ICSI with donor sperm and egg	X		X
Artificial insemination without donor sperm	X	X	X
Artificial insemination with donor sperm	X	X	X
AI surrogacy			
IVF surrogacy using intended parents’ gametes	X	X	
IVF surrogacy with donor sperm	X	X	
IVF surrogacy with donor egg			
IVF surrogacy with donor sperm and egg			
Embryo donation	X		X
Autologous sperm banking			
Autologous egg freezing	X	X	X

Table 5.1 indicated the preservation of the male line, but in Table 5.3 the same information is renamed to indicate the enabling of the biological connection of the intended father (which, again, is the *same thing*), as compared to that of the intended mother.

Table 5.3: Biological Relatedness of Intended Parents

Type of technology or service	Enables biological connection of intended mother	Enables biological connection of intended father
Fertility drugs	X	X
Surgery	X	X
IVF or ICSI using own gametes	X	X
IVF or ICSI with donor sperm	X	
IVF or ICSI with donor egg	X	X
IVF or ICSI with donor sperm and egg	X	
Artificial insemination with intended father's sperm	X	X
Artificial insemination with donor sperm	X	
AI surrogacy		X
IVF surrogacy using intended parents' gametes	X	X
IVF surrogacy with donor sperm	X	
IVF surrogacy with donor egg		X
IVF surrogacy with donor sperm and egg		
Embryo donation	X	
Autologous sperm banking		X
Autologous egg freezing	X	

All of this is to reiterate that the fertility industry has innovated multiple ways to enable intended parents to have biologically related children, but that this biological relatedness is not necessarily *genetic*. Individuals and couples may choose to use ARTs even if doing so does not preserve the intended mother's or father's genetic line, as long as it enables the intended mother

to experience pregnancy and childbirth. This is always the case with the use of IVF paired with egg donation. The birth mother may not be the genetic mother, but the intended mom still maintains a biological connection to the child she nurtures *in utero* for 40 weeks. Alternatively, in the case of surrogacy where the intended mother's egg is used, the intended mother may not experience pregnancy and childbirth, but maintains the biological connection through her genetic parentage—much like the relationship between a father and child (Rothman 2000).

Race, Nation, and the Genetic Imperative

As I indicated earlier, there is a more macro dimension of the genetic imperative that is part of a larger cultural or national zeitgeist. The drive for genetic continuity is not merely an individualized phenomenon, but is bound up with notions of nationhood, culture, race, ethnicity, and religion. According to Benedict Anderson (1991), there is an “imagined” quality to people's conceptions of themselves as members of nations and other communities, and part of the mythmaking involved in the creation of nationalist sentiments is about the relatedness of its people. We can point to many instances throughout history and today, of pronatalist policies in Israel, for example, that urge Jewish Israeli citizens to procreate at the behest of their nation (Kahn 1998), or of rape being used as a tool of genocide in civil conflicts (Das 1995; Sharlach 2000). In these cases we see the commingling of nationalist and racialized ideologies of *blood* and *genes*.

These examples point to another aspect of the genetic imperative that goes beyond the evolutionary perspective that this “drive” to reproduce oneself is part of natural selection; this is the idea that contained within the strands of DNA are bits of information that not only bind parent to offspring, of nation to citizen, but that will determine the outcome of that child. Built

into the genetic imperative, then, is the ideology of genetic determinism. When it comes to assisted reproductive technologies, the latter ideology may at times substitute for the first. For example, in the case of egg donation, the genetic imperative on the individual female line is obviously not being fulfilled, since it is the genetic code of the egg donor that will be passed on. Yet genetic determinism becomes a substitute for the genetic imperative, shaping how a particular donor is chosen; those traits are often coded in terms of race, ethnicity, and nation.

The genetic imperative is not always about passing on one's *own* genetic code. Sometimes it is about passing on the genetic code of one who is racially or ethnically similar. Packed within the genetic imperative is the idea that the genome *matters*, that it is *knowable*, that it is *racialized*, and that it is *transferable*. If one can't pass on one's own genetic code, the next best thing is, perhaps, to have some control over whose genetic code *will* be passed on. Whether one uses one's own gametes or that of a donor, the ideology of the genetic imperative is that genetics is destiny, that we can make an educated guess about a potential child's appearance, temperament, abilities, behavior, health, size, intelligence, and so on, by two routes: either by assessing the individuals whose gametes are to mingle (*in vivo* or *in vitro*), or by screening the DNA of embryos.

The text of the following advertisement appeared nestled alongside photographs of socialites, wedding announcements, and articles on the latest fashion trends in the Sunday Styles section of the *New York Times* on March 27, 2005.

The internationally renowned donor egg program at Genetics & IVF Institute (GIVF), based in suburban Washington, DC, has long met the high expectations of sophisticated patients and medical specialists from around the world. GIVF offers approximately 100 fully prescreened donors immediately available, including many Doctoral Donors in advanced degree programs, and numerous other egg donors with special accomplishments, talents, or ethnicity. Each donor is fully screened for genetic and other factors by our own medical geneticists, using laboratory methods conforming to the highest standards of reliability and sensitivity.

In large capital letters at the top of the advertisement are the words “DONOR EGG,” and in the bottom right corner we are presented with the back profile of a brunette woman’s head and shoulder, holding a baby whose round moon-face is turned towards the camera. Both the woman and the baby appear to be white, or at least fair complexioned. Presumably the woman in the advertisement represents women who have used the services of the Genetics and IVF Institute in order to procure the healthy, beautiful baby in her arms. We can surmise that she is not the genetic parent of the baby, but because of the “highest standards” of the Institute, we can rest assured that the genetic material of the woman who donated the egg that contributed to the birth of this child was of a high caliber. We cannot see the face of the mother—perhaps because the infertile women this advertisement targets are to imagine themselves in the faceless woman’s position. They, like the woman pictured in the advertisement, can have a baby with such a talented and scholarly genetic parentage, too.

Even when individuals or couples use donated gametes, thus not passing on their own genetic material, the genetic imperative is still coming into play because donated sperm and eggs are not acquired randomly. Donors are recruited, screened, filtered, managed, massaged, to fit into *genetic criteria*. Often this criteria is one of matching, that is, to find a donor who approximates the intended parent whose genes they are substituting for. This matching involves everything from ethnicity and appearance (hair and eye color, height and weight, facial features, etc.) to personality and accomplishments. In Chapter 2, I describe how the ability of egg donation programs in the United States to provide this matching service helps drive reproductive tourism to this country. This approximate matching may serve as a cover for people wishing to hide the fact that they used a sperm or egg donor, to attempt to show physical continuity within a family, ultimately to approximate, as closely as possible, what a truly genetic child would have

been like. We are not replaceable, but we can come as close as possible by purchasing the gametes of our doppelgangers.²⁰

This is evident in the practice of race- and ethnicity-matching during sperm and egg donation, implying that there is a racialized genetic code passed down by our ancestors that we then want to pass on to our own children—even the children that are not genetically “ours.” A quick perusal of the Help Wanted section on Craig’s List on any given day will usually return several ads for egg and sperm donors. Frequently, they request specific racial and ethnic backgrounds, such as one posted on January 31, 2010, looking for an Iranian egg donor (Assisted Fertility 2011). Another ad requests women who are “Asian, Caucasian, Hispanic, African, Mixed Race, All other ethnic groups. We are always searching for kind-hearted women of all ethnicities and talents to donate eggs to help infertile women and couples have children” (Fertility Needs 2011). An ad for sperm donors not only requests specific races and ethnicities, but invokes the language of blood: “We are constantly recruiting males from all ethnicities, religions, and races, but we currently have an increased need for Jewish, hispanic/Latino, full-blooded Italian, African American, and Filipino men. We also need full-blooded men of European descent with US citizenship” (California Cryobank 2011). Such advertisements imply that people of common racial and/or ethnic background share similar traits, and that these traits are transmissible. Alternatively, the advertisements could have indicated physical traits, such as olive complexion, dark hair, or full lips, but instead, race and ethnicity stand in as code words.

Racial matching was articulated by many of the fertility industry professionals I interviewed, as well. Liz, egg donation coordinator of a New York City clinic, told me about the

²⁰ Or, as I show in Chapter 6, by freezing eggs you can more adequately fulfill the genetic imperative by becoming your own egg donor.

various lists of donors that she maintains, saying, “It’s very particular screening, and there are particular things that the patients have in mind.”

Lauren: So do you, for donor egg do you tend to match for ethnicity?

Liz: Well, we match for race primarily, and then we try to get ethnicity. You know, so if we have someone who’s Caucasian, and Italian, or Mediterranean or something, we’d go that way, and if they’re Western European, or if they’re Russian, or Northern European, so we try to stick to the demographic.

Later in the interview, Liz describes a case where a Chinese client worried that a primarily Caucasian staff would not be able to adequately match her to a donor:

The whole team matches the donors with the recipients, and so she [the client] said, ‘But you guys, you Caucasians, just think that we all look the same, so how can you match me with someone that looks like me?’ And I’m like, ‘Well, I see that you have, you know, a single eyelid,’ and this and this, and duh duh duh, you know, like whatever. But, you know, I said ‘If there are certain traits or certain features that you absolutely do not want your donor to have, if you feel more comfortable doing so, send me photos of what you don’t want.’

Besides race and ethnicity, Liz and her team match by “shape, size, color, ... body type, ... skin tone and, I mean there are just a million little factors, and things, and you can tell personality, mannerisms, sometimes. If they have similar interests—I don’t know, there’s all kinds of things that help the recipient to connect with the donor, and make the process a bit easier.”

Megan, from an egg donation program in Los Angeles, also told me that intended parents tend to want donors of the same race or ethnicity, but that this is not the only basis of a match. She spoke of one Caucasian couple that initially wanted “a donor that looks like [them].”

And then we had this African American donor on our website, who had her Masters Degree in Cognitive Science. She’s a singer, classical piano player, she’s beautiful, and all these things. And they said, ‘Well, she doesn’t look like us at all, but oh my god, I just love what she wrote.’

Although race is part of the genetic imperative, it is not the only trait that people believe is transmissible between generations.

EGG DONATION AND GENETIC AND BIOLOGICAL IMPERATIVES

Egg donation is a new reproductive technology in which ova from one woman is harvested to facilitate the birth of someone else's child. For heterosexual couples, it fulfills the genetic imperative on the male line by enabling a genetic child despite the couple's problems conceiving with the woman's own ova. It also fulfills the genetic imperative for gay men, enabling one man in a gay couple to be the genetic father. The genetic imperative as it relates to genetic determinism is also invoked by a common practice in which gamete donors are extensively screened for their physical and mental health, educational background, artistic and athletic talents, and ethnicity. Such traits are seen as being transmissible through DNA, rather than the luck of the draw or cultural rearing, thus linking screening for egg donation with eugenics discourse.

During the eugenics movement of the late nineteenth and early twentieth centuries, the "fitness" of individuals determined whether or not they were worthy of propagating their gene pool through reproduction. According to British eugenicist Karl Pearson, a fit Englishman had "a clean body, a sound if slow mind, a vigorous and healthy stock, and a numerous progeny," whereas the unfit included "the habitual criminal, the professional tramp, the tuberculous, the insane, the mentally defective, the alcoholic, the diseased from birth or from excess" (cited in Kevles 1995:33). This belief about the fitness of individuals—and of entire populations— influenced by scientific and pseudoscientific theories about heredity, determined the course of positive and negative eugenic practices.

Almost a century since the heyday of eugenics, fertility clinic applications seem to imply the same divisions between fit and unfit egg donors—that is, by who is fit enough to donate

genetic material for future children. The completely unfit—those who are too old, who smoke, or who are not “height/weight proportionate”—are weeded out by the initial screening process.

Although it involves a commercial transaction, there is also an aura of altruism and goodness that egg brokers search for, and potential donors who are thought to be too greedy or overly concerned with money may be rejected. Megan, of a Los Angeles egg donor agency, describes selecting donors who “are doing this for the right reasons,” implying that she and her colleagues are skilled in assessing and distinguishing between correct and incorrect reasons for donating. Her agency also asks potential donors about their family’s health history, disqualify overweight donors, and try to pick “somebody who’s bright.”

Likewise, targeted advertisements for egg donors in elite college newspapers or on web sites, listing the qualities sought for in donors such as specific ancestry, high SAT scores, blonde hair, and musical ability, also reveals copious information about who fertility clinics and/or infertile couples believe would make a fit egg donor. For example, on the webpage for donors at A Perfect Match Egg Donation and Surrogacy Agency, prospective donors are told that:

Our egg donors are exceptionally talented women who are also highly intelligent, as measured by high scholastic achievement/outstanding scores on standardized college and graduate-school entrance exams and tests. Each donor is required to provide transcripts and official test results, such as SAT, ACT, GRE, LSAT, MCAT, and GMAT. (A Perfect Match 2008)

This agency is not unique in its requirement that prospective donors fill out extensive application forms with detailed information about virtually every aspect of their lives. According to Liz, her clinic goes “well over what is recommended and required by state and federal law.” Their screening process, which can take up to five weeks, involves blood work, physical exams, and genetic and psychological screening. By creating a biography of each potential donor that includes physical description, social history, medical history, family background, and so on,

agencies assess the fitness of each applicant to be added into their general pool or catalog of donors, and for matching with specific sets of intended parents. As Robin, director of an egg donor agency in Los Angeles, characterized her work to me, “we provide potential intended parents ... with information, detailed information on donors. And we’re always recruiting donors to provide the best available out there for them.”

Robin’s statement that she is “always recruiting” played out in a particular way for me at the end of my interview with her. As the researcher, I understood my role as the one who observes and probes the person who sits across the desk from me. Yet after I turned off the tape recorder to signal the end of the interview, Robin turned the tables on me and reminded me that those who I interview may be simultaneously assessing and judging *me*. “So,” she said to me, “Why haven’t *you* donated your eggs yet?” I can only guess that my status as a PhD student and, perhaps, my thin frame, light complexion and ambiguous ancestry, led her to classify me as a good candidate for egg donation. Although I was initially taken aback, I told her that my eggs were “too old,” and when I revealed my thirty-something age to her, she quickly agreed.

Robin was not the only egg broker who tried to recruit me during the course of my dissertation research. At a fertility conference I attended in New York, a woman representing an egg donation agency, after finding out that I was a graduate student, immediately—and aggressively—attempted to recruit me as an egg donor. Perhaps she suspected my bleeding heart nature, as she repeatedly told me about the altruistic, rather than financial, benefits of egg donation, and tried to guilt me into assenting by giving me a line about how I would be helping poor young women with cancer who have undergone chemotherapy. The experience left a seriously bad taste in my mouth. Robin and this other egg broker both made me feel as if they saw dollar signs on my ovaries. Both of these encounters have made me wonder whether egg

brokers have an “off” switch, or if they are constantly classifying every young woman they meet as a prospective donor.

Foucault’s (1995) writings about the “examination” may prove useful here. That is, in creating an individual biography of each egg donor, the screening process surveils, objectifies, documents, and codifies each donor as an individual “case.” As a result, fertility brokers and intended parents exercise power as they seek to gain knowledge about, and ultimately judge, the potential egg donor. Many of the providers I interviewed told me that, as a vital step in the assessment process, they insisted on meeting egg donors in person (or at least via Skype) before adding them to their rosters. Because they cannot ascertain the adequacy of each donor’s eggs by merely looking at her, they employ the examination/application in order to assess the intimate details of her genetic, social, familial, and medical biography and thus “constitute the individual as effect and object of power, as effect and object of knowledge” (Foucault 1995:192). Egg donors are ultimately classifiable.

This classified knowledge is sometimes presented to potential ova recipients through donor directories and catalogs from fertility clinics and agencies with photographs and detailed descriptions about their egg donors’ qualifications. The online donor directory of the Colorado Center for Reproductive Medicine, for example, even allows prospective consumers to search their database by race, ethnic heritage, eye color, and/or hair color (2009). Others provide photographs and names of their donors for anyone with an Internet connection to see. Thus at Egg Donation, Inc., one can click on the image of Amanda (#36851) and be presented with a larger of a smiling young woman, and thumbnails of more photographs of her at various ages. According to her profile, Amanda is 24 years old, Caucasian, of Canadian, Irish, and Italian ancestry, 5’8”, 155 pounds, hazel eyed, olive complexioned, with medium brown straight hair.

She is a working student, enjoys traveling, swimming, yoga and the *Twilight* series, and would like to become a Criminal Psychiatrist. She is right handed, in a committed relationship, and has donated eggs in the past (Egg Donation, Inc. n.d.). Creepily, this directory with its photographs of beautiful young women gives the impression that one is looking at an escort service or mail order bride catalog.

The directories call to mind Kevles's (1995) notion of "homemade eugenics," in which a genetic revolution, high-tech medicine and a market economy converge to facilitate "individual families deciding what kind of children they will bear" (xii). While some intended parents may seek donors who resemble them in hopes of having children they can pass off as their own genetic progeny, others may use egg donation as an opportunity for improvement. Giving your children preordained advantages in society touches on what Daniels and Golden (2004) call "populist market eugenics," in which the most desired traits are those "at the top of prevailing social hierarchies" (6). Advertisements for egg donation feed into the desires of prospective parents to breed a certain caliber of child. Purchase the eggs of a PhD candidate, say, and your child, too, will be brilliant. Not only does one have to assume that traits such as intelligence are easily passed down from genetic parent to child, but that an egg donor's genetic superiority can be revealed not by delving into her DNA, but by asking for her GPA. The desire of consumers and clinics for donors with advanced degrees, ability to play musical instruments, and Ivy League pedigrees seems to indicate that these markers of class and rearing can somehow be transmitted through one's genes; *cultural* capital is thus a manifestation of, and shorthand for, *genetic* capital. If we continue to believe that beauty, intelligence, and athletic prowess (not to mention race) are heritable qualities, and that our children's material, aesthetic, and intellectual

destinies are tied to their DNA, then we can also see how easily the genetic capital of the egg donor becomes a marketable commodity, with their cultural capital as a convenient shorthand.

Furthermore, when consumers seek a certain race or ethnicity in their egg donors, the assumption is that there is some genetic basis of race and ethnicity; by seeking donors of similar ancestral background, perhaps the consumers hope to purchase gametes that at least come from a gene pool similar to their own. Not surprisingly, if one examines the donor catalogs found on websites of fertility clinics and egg donor agencies, we are generally confronted with photographs of mostly white egg donors, followed by donors of East Asian descent, and far less of African Americans or Latinas. Yet we should not pin this hierarchy of egg donors or the desire for matching entirely on the consumer end. In my interviews with people who work with egg donors, this tendency to want to match donors and ethnicities by race seems to come as much from the providers themselves. Overrepresentation of white and Asian egg donors reflects the race of egg recipients, but it also reflects which markets are being targeted. Megan and her co-workers had previously worked for an agency whose website, as she describes it, “displayed primarily blonde, blue-eyed white donors. And so that place, we got a lot of white people.” At their new agency, they feature mixed-race and gay couples on the website in order to advertise beyond the white and heterosexual market. “We put them—they’re in the very front of our marketing. Yes we do, we definitely believe in wonderful families, however they are.”

In 1963, before the advent of egg donation, eugenics historian Mark Haller wrote of the ways in which advances in the study of genetics was leading to a revived interest in eugenics. “[While] eugenists [*sic*] generally recognize that their movement currently has only minor influence and importance, they look forward to the day when man can, by bringing his genetic future under control, do much to make human life healthier and happier” (189). It is not quite

accurate to state that eugenics as it was practiced in the nineteenth and twentieth centuries is being revived in the practice of egg donation today; it is perhaps more accurate to see egg donation in the context of neo-eugenics. Terms such as “homemade eugenics” (Kevles 1995), “populist market eugenics” (Daniels and Golden 2004), and “backdoor eugenics” (Duster 2003) indicate how contemporary genetic and reproductive technologies have introduced modified forms of eugenics. Genetic screening, prenatal sex selection, and egg donation all share characteristics of positive and negative eugenics: screening *out* the unfit, and selecting *for* desirable traits.

As a *neo*-eugenic practice, it is important to make note of how egg donation differs from earlier eugenic strategies. Egg donation is not compulsory, nor is it being enforced by the state; in the United States, at least, it is a largely unregulated market transaction. A *laissez-faire* approach is still an ideological approach, as noted by philosopher and ethicist Guido Pennings (2005a): “Neutrality of the state is impossible here. A nation without legislation on bioethical issues supports the liberal position that every citizen should decide according to his or her moral convictions” (121). Because it is not explicit social policy, the effect of egg donation is not overt manipulation or regulation of the social body. As a quite expensive infertility treatment, egg donation is available only to the few who can afford it. The *material* consequences of egg donation, even as a neo-eugenic practice, therefore, are not nearly as widespread as the popular eugenics campaigns of the first half of the twentieth century; however, the *discursive* and *ideological* consequences are just as rampant. It expands the categories of people who can now fulfill the personal drive and cultural imperative to have biological children at the same time its high price tag excludes.

Egg donation shares many worrisome similarities with old-school eugenic practices: both encourage and enable affluent (usually white) women to become mothers and raise children; seek to produce children with desirable and superior qualities while screening out less than desirable traits—and inform us about just what constitutes that fitness or desirability; share the belief that both desirable and undesirable traits can be transmitted through one’s genes; and use science and technology as both the instrument and justification for the practice. Both also have an unmistakable racialized and classed narrative, in which the “fittest” genes are those that belong to the white and the privileged.

Discourse surrounding egg donation is quite informative about the directions in which genetic and reproductive technologies may be capable of taking us. Despite the fact that the material consequences may currently seem minimal, developments in science and technology must continue to be examined in the context of the history of eugenics. In the marketplace for female gametes, the biology-as-destiny equation that drove earlier eugenic practices still lingers, as does the desire to manipulate that equation through the uses of money and technology. We should not minimize the emotions and imperatives that drive the demand for egg donation, but we must also take care not to minimize its potential eugenic implications in socially engineering populations.

The use of assisted reproductive technologies is driven in part by reproductive and genetic imperatives, both of which are means to mitigate risk and maintain control. There is, obviously, no way to *know* what a baby is going to be like or how it is going to turn out. It is, therefore, a risk people take when they decide to parent, whether that be through “natural” reproduction, assisted fertility, or fostering/adoption. There is always an element of the unknown. Technologies today, however, attempt to mitigate those risks, to give the consumers of

the technology, that is, the intended parents, some modicum of control over the “product” (L. J. Martin 2010). That can be by either using one’s own genetic material, intense screening of donors’ genetic material, and/or the manipulation of genetic material by assessing, ranking, and selecting the quality of gametes and embryos.

Lemke (2004) contends that genetic determinism and genetic risk are distinct concepts, arguing that determinism implies a causal relationship between gene and expression, whereas risk implies a relationship of prediction and calculability. The genetic imperative, as it is expressed by producers and consumers of reproductive technologies, is comprised of both phenomena, of determinism *and* risk, although different technologies may be more aligned with one than the other. In the next chapter, I explore how the genetic imperative and risk management contribute to the marketing of egg freezing technologies.

Chapter Six

Anticipating Infertility: Egg Freezing, Genetic Preservation, and Risk

Feminist scholars and writers have been analyzing and debating the social, political, and economic implications of New Reproductive Technologies (NRTs) for decades (Corea 1985; Firestone 1970; Ginsburg and Rapp 1991; Rothman 1993). As technologies grow more sophisticated, there is a continued need to study their impacts. Egg freezing (or more technically, “oocyte cryopreservation”) has recently emerged as a technology meriting such analysis (L. J. Martin 2010). Similar to other new reproductive technologies, egg freezing is not a “neutral” technology (Rothman 2000). Its development has been influenced as much by politics and ethics as it has by the pursuit of technical achievement. In Italy, for example, researchers worked to perfect oocyte cryopreservation to bypass legal restrictions against egg donation and embryo

freezing (Boggio 2005; Parmegiani et al. 2009). Elsewhere, egg freezing sidesteps controversies about the disposition of embryos, including custody battles after couples separate, restrictions on embryonic research, and “orphan” embryos resulting from unpaid storage payments (Bankowski et al. 2005). Autologous egg freezing may also potentially counter some of the exploitative dynamics of egg donation, where young women sell their ova for thousands of dollars (Steinbock 2004; Waldby and Cooper 2008). Given both the expense and the fact that success rates using frozen eggs is highly variable, desire for this technology has the potential to be another draw for reproductive tourism. However, if egg freezing becomes more effective in the future, it also has the potential to *decrease* reproductive tourism by obviating the global demand for egg donors.

No registry exists to keep track of how many women have frozen their eggs. Secondary research, however, provides us with some information about its growing prevalence. By 2008, at least 936 babies had been born worldwide using frozen oocytes (Noyes, Porcu, and Borini 2009). In the United States, more than 50 percent of clinics surveyed offer egg freezing services (Rudick et al. 2009). The process is expensive—the estimated cost of the procedure itself is approximately \$9,000 to \$15,000, with additional annual storage fees of at least several hundred dollars per year. As many experts consider egg freezing “experimental,” insurance plans generally do not cover it. Similar to sperm banking, egg freezing enables women to harvest, preserve, and store their eggs for future use; a woman’s body can age while microscopic parts of her self exist frozen in an ageless, timeless state of being. Those microscopic body parts can then be brought back to the future: they are thawed, fertilized with sperm in vitro, and transferred back into her body. She is split in two: her younger self is the egg donor, her older self is the recipient, the two selves separated by time and experience.

Sperm banks have existed since the middle of last century, enabling a time lag between gamete extraction and the eventual birth of a child (Moore 2007); this chapter explores how a functionally similar technology is now applied to women. I begin with a review of existing scholarly discourses about medicalization and infertility, arguing for the introduction of “anticipated infertility” as an ontological category to explore the time lag and its gendered implications. I then use an ethnographic mixed method consisting of a review of scientific, mainstream, and marketing literature and participant observation at fertility seminars to identify the primary populations described in these sources as potential candidates for egg freezing. The construction of their representation is demonstrative of gender norms linking women to motherhood. Egg freezing is a concise illustration of how the medicalization of women’s bodies and bodily processes masks a host of cultural anxieties about aging, illness, reproduction, and risk.

MEDICALIZATION AND ANTICIPATED INFERTILITY

Underlying the development of egg freezing is the medicalization of infertility. Once a condition or problem is medicalized, its boundaries are not static; rather, the category itself is subject to expansion (Conrad 1992). The expansion of infertility treatment demonstrates this phenomenon: technologies developed to assist one group of people with particular biomedical needs are applied to other populations with different needs and situations. With this expansion, the very meanings of fertility and infertility become redefined.

Scholars have noted the link between gender and medicalization, such that, as Lock and Kaufert (1998) write, women’s bodies are the “cornerstone of the medicalization of life,” easily appropriated for medical practice (1). From depression (Blum and Stracuzzi 2004) to HPV

vaccination (Carpenter and Casper 2009) to “female sexual dysfunction” (Cacchioni 2007), this gendered link is also evident in the medicalization of pregnancy, childbirth, and infertility (Brubaker 2007; Franklin and Ragoné 1998; Ginsburg and Rapp 1991; Rothman 2000). The advent of new reproductive technologies and practices such as IVF, egg donation, and genetic testing shifts the ways that medical authorities treat women’s bodies as potential mothers, medical subjects, and valuable resources for the production of babies at the same time it transforms cultural ideas about conception and parenting.

Gender also shapes the medicalization of infertility. Greil, Leitko, and Porter (1988) find that gender plays a crucial role in how men and women experience infertility. The women they interviewed tended to view infertility as a greater tragedy than their male partners. Women felt that their inability to have children was stigmatizing and spoiled their identities as women; as a consequence, they took on more responsibility for managing infertility treatment. Similarly, Becker (2000) describes how an inability to have children disrupts women’s gender identities. She argues that gender is “enacted” through new reproductive technologies, reproducing such cultural ideologies as the importance of continuing the male line (Lorber and Bandlamudi 1993; Rothman 2000). L. Clarke, Martin-Matthews and Matthews (2006) likewise claim that the stigma of infertility is embodied differently by women, who are more likely to use words such as “failure” and “broken” to describe their bodies, than men, who often indicate that their infertility feels emasculating.

While the link between stigma and infertility informs the use of new reproductive technologies, not all of those who use NRTs can be categorically described as “the infertile,” since not every person accessing them necessarily has an infertility diagnosis (that is, fits the criteria of being unable to achieve pregnancy after one year of frequent unprotected heterosexual

intercourse). For example, an infertility diagnosis may apply to a heterosexual couple as a single unit even if only one individual in that couple is infertile. Unpartnered individuals or lesbian or gay couples may technically be fertile but require assisted technology to achieve pregnancy (K. M. Johnson 2009; Mamo 2007). Nor is an infertility diagnosis necessarily relevant for those who use IVF paired with preimplantation genetic diagnosis (PGD) to select for or against particular genetic traits (Rothschild 2005). In all of these cases, medical techniques created to aid the infertile in achieving pregnancy have expanded to allow other categories of people have biologically-related children. At the same time, this expansion multiplies the types of bodies and pregnancies that are subjected to medicalization.

Discourse about infertility, including the stigma of childlessness, also affects the range of technologies and services available and marketed to those who do not currently plan to have biological children but may want children at some point in the future. The medicalization of infertility has expanded to such an extent that its effects reverberate throughout the fertile population – even those whose resources do not allow them to access these methods (Bell 2009). This is perhaps most evident with egg freezing technology, which contributes to the medicalization of the reproduction of those who may only anticipate infertility. The ontological category I call “anticipated infertility” may be used to describe this phenomenon. It is not a medical diagnosis, but rather a sociological descriptor for the condition in which one believes one may be infertile in the future. Although the focus here is on women with ovaries capable of producing viable ova, this new category goes beyond that demographic to encompass all reproductive bodies. Through the process of aging, all reproductive bodies will eventually be rendered incapable of having biological children without medical assistance.

The trajectory from fertile to infertile is reminiscent of Sontag's (1990) famous description of states of illness and health: "Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place" (3). This dual citizenship can also be applied to fertility: throughout our lifetimes, we hold passports in the two kingdoms of the fertile and the non-fertile. The medicalization of reproduction requires a new description of stages of the life cycle, in which the "normal" stage disappears and we are left only with pathologies: anticipated infertility and infertility. New Reproductive Technologies such as egg freezing may serve as the passport (or perhaps the border smugglers) back to the kingdom of the fertile after cancer treatments, sexually-transmitted infections, environmental toxins, or aging have placed individuals in the kingdom of the infertile.

This has particular resonance for women, whose bodies are socially and culturally linked to reproduction (Firestone 1970; Lorber 1995; McQuillan et al. 2008; Rich 1986), and may experience infertility and childlessness as especially stigmatizing. Anticipated infertility may have similarly gendered effects, creating a range of expectations or inducements to seek medical intervention. This can be extrapolated from the common practice of treating *male*-factor infertility with treatments such as IVF that require a high degree of medical intervention on the *female* partner's body (Becker 2000; Lorber and Bandlamudi 1993; Greil et al. 1988; Rothman 2000). With respect to gender ideologies that link mothering with womanhood, there may be a greater expectation for women to orient themselves to their reproductive futures, anticipating their future biological livelihoods and capacities.

Anticipated infertility relates to arguments by sociologists and anthropologists about the transformation of medicine into a science of risk analysis (A. E. Clarke et al. 2003; Conrad 2007; Rabinow 1996; Rose and Novas 2005). Contemporary biomedicalization has replaced “illness” with “health,” turning it into an individual project of social responsibility wherein technologies of risk and surveillance are used to manage and achieve an ideal state of being (A. E. Clarke et al. 2003; Rose 2007). Becker (2000) describes risk-taking in infertility treatment as a gendered phenomenon, with women taking on most of the risks of treatment; they may “experiment with their bodies out of a sense of responsibility to produce a pregnancy and their sense of entitlement to one” (101). With egg freezing, the risk analysis that leads to bodily experimentation has shifted back in time to incorporate those who are still fertile.

As an ontological category, anticipated infertility is expansive, applicable to large swaths of the population who are not diagnostically infertile. And as a medicalized condition, the power to define its parameters rests in the hands of medical authorities (Conrad 1992). Once it is defined as an “illness,” (or even a “pre-illness” or “pre-condition”), treating it as a problem becomes an imperative—not a matter of whether, but of how and when (Zola 2009). If anticipated infertility is understood to be an untenable condition, then it becomes the duty of clinicians to enable a way to “preserve” women's ability to have biological children. It also becomes an obligation of those experiencing anticipated infertility to insure their future reproductive capacity. Discourse about egg freezing renders certain bodies “treatable” for this condition, at the same time those bodies are hierarchized in terms of who are most in need or deserving of treatment.

REPRESENTATIONS OF EGG FREEZING CANDIDATES

Clinicians and to a lesser extent journalists and marketing executives often employ a curious phrase to describe egg freezing and related procedures: “fertility preservation.” In 2009 alone, 299 articles with the term “fertility preservation” were indexed in the ScienceDirect database, including 102 from *Fertility and Sterility*, the publication of the American Society for Reproductive Medicine (ASRM). The mainstream media is less likely to use this phrase (only seven articles containing this phrase were published in 2009 in major world newspapers indexed by LexisNexis), more often referring to the process only as “egg freezing.”

“Fertility preservation” is, however, a misnomer. Women who use their own thawed eggs because they cannot conceive on their own are no more fertile than those women who use donated eggs for the same reason. What *has* been preserved is not their fertility, but the *genetic connection*. “Fertility” is here being redefined as not the ability to spontaneously conceive and carry a pregnancy, but the ability to transmit one’s genetic material to future generations.²¹ This is a remarkable redefinition that has so far received little, if any, attention among medical, bioethics, or social science communities. The genetic continuity enabled by egg freezing has racial and class dimensions. Those who use donated eggs often use an extensive “matching” process to insure that egg donors share similar race-ethnic backgrounds with the intended parents, as well as markers of cultural capital such as college degrees and high SAT scores (Almeling 2007; D. E. Roberts 2009; Tuller 2010). This matching process reifies race-ethnicity, cultural capital, and even personality as genetically transmissible traits. Egg freezing takes this reification a step further by providing the perfectly matched egg donor: oneself. And, just as potential egg donors are evaluated and ranked by agencies and clinics, so too are potential egg freezing candidates placed in a hierarchy of whose fertility is most in need of preservation.

²¹ If single women freeze ova unfertilized by donor sperm, this may enable future male partners to maintain their genetic connection to the child as well. I thank an anonymous reviewer at *Gender & Society* for this insight.

Much of the literature regarding oocyte cryopreservation qualifies it as an experimental, yet promising, treatment. As a sociologist interested in the narrative constructions of users of reproductive technologies, I am less concerned with its relative effectiveness than I am with its representation. Based on my textual review and participant observation, I have identified two primary populations most often named as potential candidates for egg freezing: women cancer patients about to undergo chemo- or radiation therapy, and healthy young women who wish to pause their “biological clocks.”

A Matter of Sympathy: The Worthy Cancer Patient

Journal articles about oocyte cryopreservation often include similar elements: citations of increasing incidences of cancer among young women, discussions of the negative effects of cancer treatment on fertility, descriptions of various techniques of fertility preservation, and reports of results (Bromer and Patrizio 2008; Chang and Suh 2008; Grifo and Noyes 2010; Practice Committee of the Society for Assisted Reproductive Technology and Practice Committee of the American Society for Reproductive Medicine 2008a). Others may not include all of the above elements, but still maintain the same thread: cancer patients face infertility issues after receiving treatment, and therefore assisted reproductive technologies should be developed to help them (de Ziegler et al. 2010; Lockwood 2003; Tao and Del Valle 2008).

The clinical literature paints a common portrait of the young woman with cancer as a sympathetic subject. Not only is she faced with a cancer diagnosis and the specter of harrowing treatment, she must also contend with the fact that if she survives, she may not be able to conceive and carry to term her own genetically related child. Given the stigma of infertility and childlessness, particularly for women, an inability to bear one’s own child is seen as a tragic

consequence of cancer treatment that may be ameliorated by fertility preservation. Egg freezing, which involves hormone injections, surgery, and possibly delaying cancer treatment, becomes an embodied sacrifice for the sake of a future family. Clinicians describe fertility as a “loss,” such that “survivors and clinicians need to consider quality-of-life issues, such as reproduction, in the course of a patient’s therapy” (Grifo and Noyes 2010; de Ziegler et al. 2010). Chang and Suh (2008) lament, “In general, young female cancer patients are poorly counseled on their options for fertility preservation. Treatment of the cancer is of utmost importance, but several assisted reproductive technologies can provide relief from the uncertainty of future without compromising cancer treatments” (105).

A sympathetic portrayal of young women with cancer emerges more clearly when contrasted with another group of egg freezing candidates: healthy young women wishing to delay childbearing for non-medical or “elective” reasons. This dichotomous portrayal is highlighted in the guidelines published by reproductive medicine’s primary professional organizations, which state that oocyte cryopreservation may be considered for women with medical conditions, but, because clinical data is insufficient, “should not be offered or marketed as a means to defer reproductive aging” (Practice Committee of the Society for Assisted Reproductive Technology and Practice Committee of the American Society for Reproductive Medicine 2008b:S134). By limiting access to egg freezing technologies to a particular population, professional organizations enact a gatekeeping function. This gatekeeping marks cancer patients as more deserving of treatment than healthy young women, and exposes the socially constructed nature of egg freezing, the elusive parameters of what constitutes necessary treatment, and the power of clinicians to judge which patients are deserving of their services.

The dichotomous portrayal is, to a certain extent, also present in mainstream reportage about egg freezing. For example, a *New York Times* article reports that, “Until very recently, egg freezing . . . was carried out only in carefully controlled research settings and was available only to young women facing chemotherapy or suffering from illnesses that might make them infertile,” and contrasts this with a company now “offering egg freezing to any woman with healthy ovaries and approximately \$15,000 to spend” (Wadyka 2004). A pair of articles in the *Salt Lake Tribune* also illustrates this dichotomy. The first begins “Geeta Shah no longer has her left breast. She will have chemotherapy for the next four months, which could lead to early menopause for the 30-year-old, who does not have children but wants to be a mother” (May 2008b). The article goes on to describe Shah finding “comic relief” in selecting sperm, bonding with her mother during hormone injections and doctor visits, and feeling “like she's taking control of her life, even while giving up a part of her body” [to mastectomy] (ibid). This sympathetic portrayal of a cancer patient who decides to freeze eggs and embryos is in stark contrast with the second, much shorter article about elective egg freezing, which presents no anecdotes or quotes from any healthy young women with whom the reader could identify (May 2008a). This article includes two quotes from infertility doctors who now offer egg freezing to non-cancer patients, but also notes that ASRM advocates against egg freezing being used to delay childbearing. It ends on the following negative note: “Women under 35 should be told they likely will never use or need those eggs since most women marry by then and have an 85 percent chance of being fertile, the society says” (ibid).

Exploitation or Emancipation? The Healthy Young Woman as Subject

Although the cancer patient is almost universally portrayed in a sympathetic light in medical and popular literature, the healthy young woman who is also the target of fertility preservation efforts is a much more ambivalent figure. A 2004 *Philadelphia Inquirer* article about egg freezing contrasts excited statements by physicians such as, “The days of the biological clock are over,” with others stating that the practice is “misleading and unethical” or “absolute nonsense” (McCullough 2004). More recently, at the ASRM 2009 annual meeting, a session entitled “Should We Preserve Oocytes for Young Women to Delay Childbearing?” boasted a “standing-room-only crowd” with “rousing deliberation” (American Society for Reproductive Medicine (ASRM) 2009). In this and other forums, critics of extending the practice oppose those who argue that oocyte cryopreservation has been so successful that it should no longer be regarded as “experimental” and should be offered to any woman who requests it (Noyes, Boldt, and Nagy 2010; Richards 2010).

There are three primary narratives about this group of egg freezing candidates in the medical literature, marketing materials of clinics, presentations of physicians at symposia, and the mainstream media: (1) They are vulnerable to exploitation; (2) They are putting their own selfish needs ahead of more important priorities; and (3) They are liberated and forward-thinking.

The first narrative is one that is subtly expressed by some clinicians, and is also implied in the professional guidelines advising against social applications of egg freezing. For example, at two Open House seminars, one on each coast, physicians stated that this technique – due to its potential complications, costs, and experimental status - should only be indicated for patients prior to undergoing treatment for cancer or gynecological diseases. Even more firmly, a physician at the New York clinic derided the marketing of egg freezing to healthy young women

as a cynical commercial venture, and raised concerns about the social consequences of possibly coercing young women to freeze their eggs for the sake of their careers.

De Melo-Martin and Cholst (2008) echo these worries about the social consequences of egg freezing, arguing:

[V]ulnerable patients and healthy young women are being offered oocyte cryopreservation commercially with critical information still lacking. This is ethically questionable: lack of data about safety and effectiveness puts patients and their offspring at risk, precludes women from making really autonomous decisions, wastes scarce resources, and undermines public trust in the medical profession. (523)

Similarly, in a packet of materials handed out at another Open House, an article co-written by its medical director states, “Presently, given the status of current technology, any representation that egg freezing provides any assurance that women can presently preserve their fertility by banking their eggs for future use is both empty and misleading and will ultimately lead to major disappointments with an inevitable public backlash” (Sher and Keskinetepe 2005:1). Bioethicist Harwood (2009) argues that the marketing of egg freezing to healthy young women may be “commercially exploitative,” especially when they are led to believe that banking their eggs can serve as a form of insurance against future infertility (39).

This narrative frames egg freezing by healthy young women as exploitation; encouraging young women to pay large sums of money to freeze their eggs when the technique is still largely experimental is cast as exploitative, and the consumers portrayed as naive. Underlying this particular narrative, however, is the willingness of many assisted fertility providers—as indicated in the professional guidelines and the call to amend them—to offer elective egg freezing to healthy young women once the technology is no longer classified as experimental.

In the second narrative, which appears in the popular—though not the medical—literature, the healthy young woman’s decision to freeze eggs is portrayed as a selfish move,

unlike the altruism of the cancer patient who is willing to subject her body to invasive treatments to fulfill future family obligations. The selfish/altruistic dichotomy represents two sides of the same gender ideology of motherhood as role fulfillment. In the first instance, freezing eggs is selfish because it delays motherhood, whereas in the second, freezing eggs is altruistic because it enables it.

Anxieties around social applications of egg freezing resonate with conservative views that blame education- and career-oriented young women for the breakdown of the family. In a newspaper article published in the United Kingdom, for example, the author writes, “In the next few years, hundreds—perhaps thousands—of perfectly healthy women could soon be regarding egg freezing as their ‘safety net’. [Is] it really something we should be applauding? Should we really be encouraging a generation of women to put off motherhood for another decade?” (J. Johnson 2004). These are merely rhetorical questions, however, and the author does not advance this particular narrative in the rest of her article. In fact, this narrative is primarily used as a rhetorical device, easily torn down to justify egg freezing for social reasons. For example, a British woman who has decided to freeze her eggs tells a reporter:

‘Tabloid newspapers talk about selfish Bridget Jones types putting their eggs on ice so they can carry on partying until the last gasp before the menopause. My own circumstances are nothing like that; nor are those of the other single women I know who are in their thirties and yearning for babies. We are not selfish, we are not out partying at the expense of our personal lives--we are out, not at home, looking for an adorable husband and potential father.’ (Chaudhuri 2005)

As a rhetorical device, this narrative links delayed marriage and childbearing for the sake of education, careers, and the search for “Mister Right” with the reproductive consequence of declining fertility.

The third narrative articulates egg freezing as an empowering answer to anticipated infertility. Some physicians and bioethicists argue that egg freezing will “emancipate” women by

enabling them to achieve reproductive parity with men (Homburg, van der Veen, and Silber 2009). By using technology to delay childbearing, women gain equal participation in employment, time to find a partner and become psychologically ready for children, and “insurance” against future egg failure (Goold and Savulescu 2009).

This narrative is most common in materials marketing egg freezing. A session at an egg-freezing seminar advertised in a direct marketing email message as “The Biological Clock: Take Control of Your Dating Life,” featured a panel composed of a fertility doctor, a clinical psychologist, and a self-described “dating expert.” The theme of empowerment was especially promoted by the latter two panelists, most explicitly by the dating expert who began her talk with the words “Knowledge is power.” The psychologist and the dating expert framed egg freezing as a way to give women a sense of control over their bodies, their lives, and their fertility.

Presumably secure in their knowledge that they have eggs banked, women can concentrate on their careers and finding a partner instead of panicking about being single and getting older. At the same time the audience was meant to be flattered by being described as high-achieving, take-charge kind of women, they were also shamed with the words, “Men can see your desperation.” The take-away message was that freezing eggs makes women feel more confident and appear less desperate, which will make them more attractive to men. The heteronormativity of the event was all too palpable.

EGG FREEZING, FEAR, AND THE MANAGEMENT OF RISK

As the last narrative suggests, the framing of egg freezing as empowerment may be coupled with fear—in this case the twin anxieties of aging and singlehood. At the beginning of the seminar described above, I quietly sat and observed my surroundings as I waited for the

panel to begin. On every chair was a folder from the egg freezing company with information sheets about the process, an “Egg Freezing Quiz,” biographies of the evening’s speakers, press clips, and an oversized postcard. Seated together across from me were two women who looked to be in their thirties. One woman pulled out the postcard and pointed it out to her friend who, in reply, shook her head and audibly groaned. On one side of the card was a smiling young white woman giving a bath to a baby, and to the left were the words “Set your own biological clock,” with the name of the company below. The flip side of the card read: “DID YOU KNOW... Egg quality begins to decline at 27 and significantly deteriorates every year past 35. But, now you have options!”

The link between anticipated infertility and anxiety is made even by well-intentioned physicians and patient advocacy organizations. A national non-profit organization that bills itself as a resource for intended parents has recently been promoting a new infertility prevention campaign aimed at young women.²² Although they do not endorse egg freezing, per se, their literature and events raise rather than assuage fears related to anticipated infertility. For example, the cover of their pamphlet on infertility prevention features a young white woman wearing nothing but a black hat, black bra, and black lace-edged panties. Her face is in profile, and in her hands she holds an enormous clock, right over her pelvic area. This message, graphically emphasizing the ticking of a biological clock, is reiterated in this organization’s infertility prevention events held in nail salons in cities throughout the United States. At the event I attended, women in their twenties and thirties drank cocktails, had manicures, and ate cupcakes as the invited fertility doctor presented statistics about the rapid decline in egg quality and

²² This group, which also organized the two conferences I attended, offers free services for intended parents online, in-person, and over the telephone, including coaching, resources, news, and public seminars. Their sponsors include clinics, government agencies, and pharmaceutical companies.

quantity after age 37.²³ Unsurprisingly, the very first question he received from the audience was about egg freezing.

Anticipated infertility is as palpable for the cancer patient as it is for the healthy young woman not yet ready or able to have children. Autologous egg banking is a technology of risk management in anticipation of future infertility, enabling women to “bank” on having a frozen supply of ova when they are finally ready to procreate. As one doctor cogently explained to his audience of potential egg-freezing clients, we must make a cost-benefit analysis: “What are the costs of doing it versus not doing it?” Egg freezing is thus marketed as a way to mitigate the risk of not being able to spontaneously conceive in the future, which relates to the risks of being childless, not experiencing pregnancy and childbirth, and not having a genetically related child. Implicit in this last notion is that having a child that is genetically related to its mother is less risky than to have one through egg donation or adoption, as if the genetic material a mother passes on to her child is a “known quantity,” giving the egg freezing consumer a modicum of control over her reproductive future. The risk of genetic discontinuity is not merely an individualized phenomenon, but is bound up within discourses of nationhood, race, and ethnicity, in which children are not blank slates but are born with cultural and racial histories embedded within their DNA.

CONCLUSION

Oocyte cryopreservation developed as a supplement to IVF for infertile couples, but the technique has since experienced mission creep, with its target market shifting from the infertile to women cancer patients and healthy young women planning for their reproductive futures. This

²³ The age cited by this physician at which egg quality declines differed by ten years from the marketing postcard described above.

shift exposes the need to formulate new ontological categories in discussions about new reproductive technologies and the fertility industry. As Mamo (2007) succinctly argues, current biomedical definitions of infertility that require a year of regular, unprotected heterosexual intercourse “privileges the identity category of heterosexual, thereby creating a moral order around reproduction” (30). In addition to lesbians, gay men, and unpartnered individuals, there are many other categories of people who cannot be classified as “infertile” yet still access or desire access to New reproductive technologies.

To address one of these sub-populations, I have identified “anticipated infertility” as a state of being in which future infertility is predicted. This ontological category allows us to analyze the discourse surrounding the two primary candidates for egg freezing, and their various portrayals as sympathetic, vulnerable, selfish, or liberated subjects. Their candidacy depends upon anxieties and fears of anticipated infertility and the stigma of childlessness, and is informed by the reproductive imperative. The dichotomous response to the candidacy of women cancer patients versus healthy young women only underscores the expectation that women must sacrifice (their bodies, their careers) to become mothers and hence live up to gendered ideals.

On top of the reproductive imperative can now be laid the genetic imperative. “Fertility preservation” is a term often used within discourse about egg freezing to describe the solution to the problem of anticipated infertility. However, egg freezing merely preserves the ability to have a genetically related child. The very meaning of fertility (and, in turn, infertility) is redefined to emphasize the genetic connection. This genetic connection is reified as the gold standard of motherhood, circularly highlighting the necessity to address anticipated infertility by such measures as egg freezing.

As a tool of risk management, egg freezing is a technomedical remedy of displacement, ameliorating fears of childlessness and the reproductive and genetic unknown at the same time it puts women's bodies and bank accounts at risk. Financial optimization has become another category to consider in the risk or cost-benefit analysis of biomedicine. Egg freezing, similar to other forms of autologous tissue banking, is future-oriented, becoming more valuable frozen and stored than left to age contained within the body (Waldby and Mitchell 2006). By reducing the inevitability of anticipated infertility, frozen eggs are not only an investment for a woman's own future reproductive needs, but they may be a financial investment (at least for the healthy young woman), allowing her to spend her childbearing years acquiring education, skills, job promotions, and money. For both healthy women and cancer survivors, assuming that their stored ova are viable, having eggs banked may eliminate the need to financially compensate an egg donor in the future.

Egg freezing reflects, responds to, and reinforces contemporary demographic and social phenomena such as rising rates of cancer and infertility, delayed childbearing, and a persistent ideology that ranks the ability to have (genetic) children as the fulfillment of gender norms. It is, in the end, a technomedical fix. By analyzing brand new reproductive technologies, scholars are reminded of how trends of medicalization and risk analysis intertwine and interact with our bodies and our technologies.

Conclusion

Governmentality, Biocitizenship, and the Neoliberal Exception

Countries' regulation of fertility services is a form of biopolitical governmentality, and can be put in the broader context of policies governing reproduction (Foucault 2007). The state as disciplinarian shapes the population, determining who is "fit" or "unfit" to procreate and raise children (i.e. what kind of bodies can or can't be born and thrive), at the same time it creates, limits, reinforces and defines ethical and moral standards for its populace (i.e. what one can or cannot do with one's body, what counts as a "body" or a "person," and who has ownership or jurisdiction over those bodies and persons) (Agamben 1998; Foucault 2007; Hashiloni-Dolev 2007; Rose 2007). Furthermore, biopolitical regimes involve not only state actors, but also include other institutions with disciplinary functions, including Medicine, Education, and the Family.

Biopolitical regimes are concerned with the matter of what one can or cannot do with one's body. The state and other norming institutions are involved in overseeing and surveilling end of life decisions, organ donation, sex work, and body modification. Policies raise questions, for one, about human biological materials: what citizens may have injected or implanted in their body, what they are allowed to expel or have surgically removed, what they are allowed to buy, sell or rent from another person. In addition to policies determining what an abstract person may do with his or her body, they also delineate *which types of persons* are allowed to take part in the buying, selling, renting, extracting, and implanting, in what circumstances, and how often. Reproductive practices, including abortion, contraception, and assisted fertility, moreover, have *direct* and *immediate* demographic implications, and fall under the realm of both the state and the

medical profession. This form of governmentality frequently happens through, and about, *women's* bodies (even though men are also involved in roles as genetic and/or social fathers).

As this project describes, regulation of reproductive technology and services currently varies throughout the world, and this is where the matter of reproductive tourism enters the picture. Reproductive tourism is decidedly *not* only about Westerners traveling to Third World countries to consume cheaper fertility services; reproductive tourism to the United States, where fertility services are quite expensive, is currently thriving. Moreover, those who travel to the United States are not coming from countries that are wealthier than the United States, or that lack their own fertility industries. A major difference between the United States and these other nations is the regulation of reproductive matters, including the uses of assistive technology and family law regarding paternity.

If governments enact laws to structure the fertility options of their citizens, yet some individuals, despite these laws, are able to leave their countries' borders to pursue forbidden services elsewhere, what does this say about the reach of biopolitical governance, or of citizenship itself? All citizens, significantly, are not equally subject to the state's enforcement of rules and regulations. The advent of reproductive technologies, which have already contributed to the fragmentation and commodification of procreation, also contribute to the neoliberalization of procreation as a largely unregulated, private, free-market transaction. That is, when procreation moves out of the bedroom and into the laboratory, when bodily materials are bought and sold like any other commodity, the hands of the market *and* the government play powerful roles in both *how* and *what type of* babies are made.

Reproductive tourism may seem to undermine the governmental function of the state if we think of the state as an all-powerful actor enforcing rigorous controls over its population.

After all, if citizens can thumb their noses at legislation banning or criminalizing a particular service they then seek out in another country with more lax policies, are they not subverting the governmental reach of the state? Reproductive tourism instead must be seen as a *response* to governmentality, as a practice that is itself *produced* by governmentality: attempts by the state to control the reproductive actions of its citizens through regulation leads to the subversion of those very same regulations. This subversion itself is facilitated by neoliberal free market ideology and practices. In Ong's (2007) terms, we may describe this as a "neoliberal exception," in which global capitalist forces undermine regulatory functions. Reproductive tourism as a neoliberal exception is, however, a stratified phenomenon that only exists for a privileged subset who are able to subvert the mandates of the state. The less privileged who cannot maneuver around restrictions and prohibitions are still subject to governmental regulations on their reproductive autonomy.

Governmentality does not disappear in the face of reproductive tourism; rather it is interactional, and we see governmental responses *to* reproductive tourism. Just as we can identify different types of governmental regimes, there are also different types of responses. New South Wales, Australia, for example, offers a protectionist response that prohibits even those commercial surrogacy arrangements that occur in other geographic locations. The neoliberal response, on the other hand, capitalizes on the unmet international demand for fertility services by allowing hubs of reproductive tourism to flourish within its borders. This response is exemplified by the United States, India, and some Eastern European nations.

BIOLOGICAL AND FLEXIBLE CITIZENSHIP PROJECTS

In addition to conceiving of reproductive tourism as a “neoliberal exception,” the phenomenon also aligns with Rose and Novas’s concept of “biological citizenship” (2005; see also Rose 2007). By this term, the authors refer to a kind of *social identity* that links one’s sense of self as a citizen to “beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as population and races, and as a species” (Rose and Novas 2005:440). Biological citizenship can move beyond the self-motivated individual to take on an active, biosocial form (Rabinow 1996), in which people align with others who share similar biological conditions (and their advocates) to advance their position, and may see governments and/or medical authorities as allies or as antagonists. Thus acts of biological citizenship may include ACT-UP activists fighting for more federal dollars to go towards AIDS research, or victims of 9/11 suing the United States to provide for their unique health care needs.

People with infertility conditions or who are unable to have children on their own for social reasons have started support groups and advocacy organizations including RESOLVE and the American Fertility Association, and involvement in these organizations is an enactment of both biological citizenship and biosociality. Rose’s (2007) emphasis is on an activist biocitizenry. He even writes, “Biological citizenship requires those with investments in their biology to *become* political” (149). Yet political acts may not be collective or even conscious. Those who cross national borders in order to obtain fertility services may or may not be involved with any advocacy organizations, but the very act of engaging in transnational reproduction has political overtones, particularly when it occurs as a means to enact one’s personal reproductive autonomy in the face of restrictive laws and policies one disagrees with.

In this respect, my interpretation of biological citizenship does not require an activist orientation or even an acknowledgement that this social identity is shared by others. Rather than

a politics of social justice, biological citizenship may be motivated by a politics of entitlement. This interpretation of biological citizenship also relates to Ong's (1999) concept of "flexible citizenship," which includes "the localizing strategies of subjects who, through a variety of familial and economic practices, seek to evade, deflect, and take advantage of political and economic conditions in different parts of the world" (113). Cognizant that different rules apply in different state regimes, a hypermobile, economically privileged segment of the world population seeks to work, invest, be educated in, and raise families in the places that are most advantageous for these particular activities. Thus the United States, with its lax regulations, high-technology resources, amenable courts, birthright citizenship, and a class of relatively young and healthy women willing to act as third party egg donors and surrogates, becomes an ideal Mother Country for those flexible citizens desiring children through assisted fertility.

Moreover, those who engage in reproductive tourism are not necessarily forgoing one form of national citizenship to take advantage of another, but, instead, take their national citizenship for granted as they enact their biological citizenship. This is a different dynamic than cases of so-called "anchor babies," in which giving birth to a child in the United States is framed as a first-step on the road to securing United States citizenship for additional family members. Take for example the recent case in which a French couple has unsuccessfully fought for ten years to get the French government to recognize their twin daughters, born via surrogate in California, as French citizens (Associated Press 2011b). By virtue of their birth in the United States, the daughters are American citizens, in the eyes of both American and French law. What is as yet unresolved is whether the couple should be recognized as the natural parents of their daughters and thus transmit to them French citizenship—California law says yes, French law says no. Flexible citizenship and the politics of entitlement plays out in that the French couple

felt *entitled* to subvert French law by traveling to California to obtain a prohibited service, felt *entitled* to obtain parentage through the California court system, and felt *entitled* to have their daughters recognized as French citizens despite the illicit nature of their birth in another country.

The collision between biological citizenship and flexible citizenship as exemplified by reproductive tourism may ironically be constructed as a nationalist project, as citizens of one country go to extraordinary ends, involving people, governments, and industries of other nations to produce more citizens for their own home country. Further, as long as the gametes of at least one of the intended parents is being used to produce these transnationally-derived children, it is not only *citizenship* that is being transmitted, but genetic continuity. Although Rose (2007) downplays the racialized and eugenic overtones of contemporary manifestations of biological citizenship, the “genetic imperative” is ever present and at play in reproductive tourism and indeed undergirds the entire fertility industry.

With acknowledgments to Rose and Novas and Ong, I describe reproductive tourism as an enactment of *global biocitizenship*. That is, individuals residing in nations where they cannot obtain the reproductive technologies they desire (because they are too expensive, unavailable, or illegal) are transformed into *global biocitizens*: they enact a kind of citizenship based on their biological/reproductive desires on a global stage. Reproductive tourism is not the only instance—the same phenomenon is evinced by transnational adoptive parents (Dubinsky 2010), by people who cross national borders to purchase organs for transplant on the black market or in places where organs are sufficiently commodified (Lock and Kaufert 1998; Scheper-Hughes and Wacquant 2002), by those who engage in medical tourism for sex reassignment surgery (Aizura 2009), and by American seniors traveling to Canada to fulfill their prescriptions (Khosravi 2003). In all cases, global biocitizens may not conceive of themselves as being a part of a larger

social movement. They indeed may be acting purely out of self-interest. Yet, what is true about both organ trafficking and international commercial surrogacy is that global biocitizens cannot act alone: they rely on a global network to facilitate this trade in bodies and body parts, of surgeries and pharmaceuticals, and they travel to places where this facilitating network thrives, either legally *or* in the shadows.

Global biocitizens do not operate or exist outside the realm of governmentality. Rather, they invoke a kind of free market subjection, choosing to subject themselves to other regions' modes of governmentality that better suit their biological/reproductive needs and desires than the country in which they are citizens by right of birth or naturalization. We may think of these citizens as "unruly," as they who cannot be contained or constrained—but this unruliness is frequently sanctioned by governments that turn a blind eye to subversion by the socially, politically, and economically advantaged. The less privileged, however, remain subject to governmental controls, and often have no choice but to be compliant citizens, without the babies or organs that they, too, desire.

The subjection of global biocitizens to extraterritorial governmentality is exemplified by those individuals who travel to the United States to obtain the services of surrogates. These individuals do not exist in a nether zone absent of law; rather, they turn away from laws in their home countries that forbid contracting with another woman to gestate a baby, and towards laws of foreign governments that recognize surrogacy contracts. Thus we see that providers of fertility services often employ or contract with family law attorneys cognizant of state legislation and court jurisdiction about paternity. Jurists in the United States play a role in this as well, by allowing noncitizens and nonresidents to petition American courts for paternity, voiding the legal

maternal tie to the surrogate. Yet, as the French case reveals, decisions made in California courtrooms do not necessarily apply in France or elsewhere.

FUTURE RESEARCH

In this dissertation, I have analyzed the United States fertility industry and its position within the global fertility market from the point of view of American providers. My theorizing about the logic of reproductive tourism has been colored, then, by the subjective perspective of those who provide assisted fertility services. This is not unimportant data: it is, after all, the providers who create and sustain the thriving fertility industry, it is they who market their services to an international consumer base, and it is they who join professional organizations that lobby for the continued laissez-faire climate regarding reproductive technologies.

What is missing, however, is the perspective of the intended parents themselves. Providers told me what they believed to be the primary reasons why their international clients sought out services in the United States. Although they were in part reporting back to me what they had heard from their clients, their answers also reflected speculation. For future research, I would like to interview a comparable number of intended parents who had traveled here from abroad to at the very least verify or contradict what the providers told me. That is, do their perspectives match up? Do providers and intended parents identify the same reasons for reproductive tourism? Are there other contributing logics that are not obvious to the providers?

CONCLUSION

Those who defend reproductive tourism may use the language of reproductive freedom and rights, couched in universalism. If one has the “right” to have a child by any means possible,

is it not their right to travel elsewhere as an act of civil disobedience? Is this not their duty as liberal global biocitizens? As Ong (2007) writes,

We are now at a historic moment when new rules are set by the neoliberal exception, which enforces the internalization of ideals of 'self-responsibilization.' American neoliberalization is now articulated by the Bush administration as 'every citizen an agent of his or her own destiny.' American liberty is tweaked to mean freedom *from* state protection and freedom to respond autonomously to the turbulence of global markets. (172)

Globalization and the ease of movement across borders by global elites adds another dimension to this equation, in that the self-responsibilization articulated by Ong applies not only to American citizens, but to any global elite who can afford to take part in neoliberal American dreams of unfettered business and consumerism. Notions of American liberty and freedom from state protection are value-adding marketable selling points aimed at global elites to consume the goods and services of American industries and corporations. Much like small island nations marketing their off-shore tax havens and export processing zones, or like the Netherlands marketing its liberal drug and prostitution laws, the United States markets its neoliberal biopolitics and positions itself globally as a Mother Country, as a producer of babies for a global citizenry.

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