Not bought but sold: Navigating Canada's *Assisted Human Reproduction Act* abroad and at home

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Abstract

Infertility technologies utilizing donor eggs pose ethical and moral challenges, in part, because they have the potential to commodify women's bodies and they also require women donors to undergo an invasive, time intensive, and medically risky procedure. Simultaneously, these technologies allow couples and individuals to build families who may otherwise be unable. Some countries have addressed donors' risks and reproductive labour, allowing for compensation (e.g., Czech Republic and Spain) and even payment (e.g., the United States) to women to donate and to build the market. However, other countries, such as Canada, have raised yet other ethical concerns with egg donation, namely that payments to donors could incentivize "vulnerable" women to undergo unnecessary risks, and also commodify bodies and gametes. In response, in 2004, Canada passed the *Assisted Human Reproduction Act* (*AHRA*), which only allows donors to be minimally compensated for their receiptable expenses. This has created a shortage of Canadian donors, leading intended parents in need of egg donation to look for other ways to obtain donor eggs both within and outside of Canada. This study follows the pathways that Canadians take to find egg donors. Through 98 in-depth interviews with Canadian recipients and fertility professionals from Canada, the Czech Republic and Spain, I illustrate how Canadians continue to engage in commercialized egg donation, despite its prohibition, importing frozen eggs from the United States, and traveling to places such as the Czech Republic and Spain to procure eggs. In the thesis, I describe three main findings. (1) In response to the restrictive Canadian legislation, Canadian medical professionals do "boundary-work" to dissociate themselves from the ethical and legal questions surrounding egg donation. Medical professionals adapted their practices to avoid legal and ethical threats, and in doing so, medical professionals maintain their professional authority over the practice of egg donation. (2) Even within the

Canadian altruistic system of egg donation, eggs continue to be commodified. I show how the gift/commodity dichotomy ignores the types of exchanges that currently occur in favor of simplifying the moral argument that links commodification to the unethical and altruistic exchanges to the ethical. In complicating this dichotomy, I argue for the examination of the social relationships that are formed when eggs are exchanged. (3) While the global exchange for eggs is partially dependent on the interactions between countries with restrictive and liberal legislation, how countries with liberal legislation attract potential clients to their clinics, depends on these clinics' knowledge of their potential clients' desires for medical care, and the clinics' ability to cultivate trust amongst their clients. These international fertility clinics use strategies in action to institutionalize cultural health capital (CHC). International fertility clinics mobilize CHC which further stratifies reproduction as it institutionalizes who fertility care is meant for (i.e., white, Western women). These findings detail the ways in which Canadian engage in the globalization of reproductive services, illuminating how the ease of medical travel and the existence of a global marketplace for eggs makes it difficult for country-level legislation to restrict the commodification of donation. In taking a global empirical approach to egg donation, I provide a more thorough understanding of the ways in which eggs are exchanged within this global marketplace. This research explicates the intersections between biomedical technologies, public policies, professional practices, and gift/commodity exchanges to highlight current bioethical and sociological questions of professional authority and the ethical consumption of new medical technologies.

Résumé

Les technologies de procréation assistée ayant recours aux dons d’ovocytes posent des problèmes éthiques et moraux, en partie parce qu’elles risquent de transformer le corps de la femme en marchandise et qu’elles nécessitent que les donneuses subissent des procédures invasives, coûteuses en temps et médicalement risquées. Simultanément, ces technologies offrent la chance à des couples et des individus de fonder une famille, sans quoi cela leur serait impossible. Certains pays ont adressé les problèmes en lien avec le travail génésique et les risques que courent les donneuses en permettant la compensation (ex. : la République Tchèque et l’Espagne) et même la rémunération (ex. : les États-Unis) des femmes pour leurs dons, ce qui a également servi à développer le marché. Toutefois, d’autres pays, tel le Canada, ont soulevé davantage de préoccupations éthiques concernant les dons d’ovules, et plus précisément en ce qui a trait à la rémunération des donneuses qui pourrait inciter les femmes « vulnérables » à courir des risques inutiles en plus de transformer leur corps et leur gamètes en marchandise. En 2004, en réponse aux inquiétudes, le Canada a passé la Loi sur la procréation assistée qui permet seulement que les donneuses soient indemnisées de façon minimale pour leurs dépenses recevables. Cela a créé une pénurie de donneuses canadiennes, ce qui a induit les futurs parents ayant besoin de dons d'ovocytes à chercher d'autres moyens d'obtenir l’accès à des donneuses tant au Canada qu'à l'étranger. La présente thèse suit les voies empruntées par les canadiens pour trouver des donneuses d’ovocytes. Par le biais de 98 entretiens approfondis avec des futurs parents canadiens et des professionnels de la santé provenant du Canada, de République Tchèque et d’Espagne, j’explique comment les canadiens continuent de participer au don commercial de gamètes, malgré son interdiction, en important des ovocytes congelés des États-Unis et en voyageant dans des pays tels que la République Tchèque et l’Espagne afin de se procurer des ovocytes. Dans cette thèse, je décris trois résultats principaux. (1) En réponse à la législation restrictive du Canada, les professionnels canadiens de la santé utilisent le « boundary-work » afin de se dissocier des questions éthiques et juridiques relatives au don d’ovocytes. En adaptant leurs pratiques pour éviter les menaces éthiques et juridiques, ces professionnels de la santé conservent leur autorité professionnelle sur la pratique de don d’ovocytes. (2) Bien que le Canada ait instauré un système altruiste de don d’ovocytes, la marchandisation des ovocytes continue. Je montre comment la dichotomie dons/marchandise ne tient pas compte des types d'échanges qui se produisent actuellement en faveur de la simplification de l'argument moral qui lie la marchandisation à l’immoral et les échanges altruistes à l'éthique. En compliquant cette dichotomie, je plaide pour l’inspection des relations sociales qui se forment lorsque les ovocytes sont échangés. (3) Bien que globalement, l’échange d’ovocytes dépend en partie des interactions entre les pays à législation restrictive et libérale, la manière dont les pays à législation libérale attirent les clients potentiels dans leurs cliniques dépend de la connaissance des cliniques quant aux désirs de leurs clients potentiels en matière de soins médicaux et de la capacité des cliniques à cultiver la confiance chez leurs clients. Ces cliniques de fertilité à l’étranger utilisent des stratégies pour institutionnaliser le capital culturel de la santé (CCS). Cette mobilisation du CCS par les cliniques de fertilité étrangères amplifie la stratification de la reproduction en institutionnalisant ceux pour qui les soins de fertilité sont conçus (c’est-à-dire les femmes blanches occidentales). Ces résultats décrivent les façons par lesquelles le Canada participe à la globalisation des services de procréation assistée, soulignant à quel point la facilité du tourisme médical et l’existence d’un marché d’ovocytes mondial rendent difficile la législation de niveau national voulant limiter la marchandisation des dons de gamètes. En appliquant une approche empirique et globale au don d’ovocytes, je permets une compréhension plus approfondie de la manière dont les ovocytes sont échangés à l’échelle mondiale. Cette recherche explique les intersections entre les technologies biomédicales, les politiques publiques, les pratiques professionnelles et les procédés de dons et de marchandise afin de mettre l’accent sur les enjeux bioéthiques et sociologiques actuels en lien avec l’autorité professionnelle et la consommation éthique des nouvelles technologies médicales.

Abbreviations

AHRA: Assisted Human Reproduction Act
ART: Assisted reproductive technologies
ASRM: American Society of Reproductive Medicine
CARTR: Canadian Assisted Reproductive Technology Registrar
CFAS: Canadian Fertility and Andrology Society
CHC: cultural health capital
CZ: Czech Republic
ESHRE: European Society for Human Reproduction and Embryology
EU: European Union
IVF: in vitro fertilization
NAC: National Action Committee on the Status of Women
OHSS: ovarian hyperstimulation syndrome
PCC: patient centered care
SP: Spain
USA: United States of America

Contribution to original knowledge

This dissertation contributes to the sociology of medicine, sociology of professions, and bioethics by providing a unique analysis of the pathways by which Canadians find donor eggs under the *Assisted Human Reproduction Act (AHRA).* It also shows how Canadian fertility practioners responded to this act and the ways in which abroad fertility professionals care for Canadian patients. A version of chapter 4 has been previously published in *Social Science and Medicine.*

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Contribution of the author

The following dissertation was sole authored.

Chapter 1
Introduction

The day that I found out that I had the premature ovarian failure, within a few hours, I called [my sister] up and I told her what the situation was. . . she actually immediately said, “Oh like can I give you eggs?” –Alex

[The fertility clinic] gave me a list of egg banks in the States that I could utilize. And then I did some online research and found Egg Helpers and Little Miracles [both Canadian egg donation agencies], operating out of Ontario and registered for them. It took seven egg donors, but we secured one through Little Miracles. –Sam

I don’t have a sister. I don’t have anyone in our lives that I felt like I wanted to ask for an egg and we started looking at going to the States and we started googling egg donors. . . and I came across a service in the States that said . . . they took Americans to Prague or to somewhere in the Czech Republic and sort of worked as a go between the Czech clinics and the people they took over there and how it was cheaper and easier to go over there and it would save all this money and so I sort of started directly researching these clinics that were in the Czech republic. –Macie

We were absolutely interested in [going] the anonymous route instead and so…my doctor said…what you have to do is purchase eggs from the US. –Rhonda

Alex, Sam, Macie and Rhonda are all white, Canadian, upper-middle class women in their early to late forties who were infertile and attempting to become pregnant using an egg donor[1]. Above they describe the ways that they used their family members, Canadian egg donation agencies, abroad clinics, and frozen egg banks to find an egg donor in the mid-2010s. In this dissertation, I trace these pathways available to Canadian women who require an egg donor to achieve pregnancy, and how the *Assisted Human Reproduction Act (AHRA 2012),* which prevents the payment of egg donors, shapes these routes. Each option has different moral and material consequences for not only the women pursuing egg donation, but also the fertility professionals who provide these women with care[2]. This dissertation explores the ways that these multiple actors navigate and understand the ethics and realities of using another woman's eggs for the creation of families in a globalized system of fertility care.

EGG DONATION: A MEDICAL PROCEDURE WITH ETHICAL AND SOCIAL CHALLENGES

When seeking assisted reproduction services, most women experiencing female-factor infertility will be prescribed in vitro fertilization (IVF), a medical procedure that involves harvesting a woman's own eggs and fertilizing them with sperm in a petri dish. The embryos that are created are then transferred back into the woman's uterus. However, some women who are

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[1] The medical term for human eggs is oocytes. However, in this dissertation, I use the more colloquial term as my participants all referred to oocyte donation as "egg donation." "Egg donation" was also the words used on clinic websites to describe this procedure. I use the term, "egg" instead of "ovum" or "oocyte" as it is the colloquial term used to describe the gametes produced by the female reproductive system. My participants, sociologists of reproduction and newspaper articles written on this topic also used "egg".. Thus, in order to facilitate continuity and conversations between these various discourses, I also use the term "egg." While the term "donation" suggests that the exchange of eggs was always altruistic, I use the term "donation" to describe exchanges, even if those exchanges resulted in payment to the donor. I do this to reflect the language used by recipients and fertility practitioners. Although sociologist of reproduction have noted how donation may obsure the exchange that is taking place for a more morally palatable one, they continue to use largely, "donation" rather than exchange.

[2] These pathways also affect the egg donors; however, in this dissertation, I only interviewed women who had used donors and medical practitioners. I limited the scope of this dissertation to provide an understanding of how these moral actors negotiated the *AHRA* and their ethical values for procuring eggs.

unable to produce quality oocytes (eggs) due to factors such as age-related infertility or premature ovarian insufficiency will require the use of an egg donor to achieve pregnancy. In 2017, egg donation made up approximately ten percent of all in vitro fertilization cycles in Canada (3,273/33,092) ("Canadian Assisted Reproductive Technologies Register Plus" 2018). Although this medical treatment offers increased chances of pregnancy (31-56%) for women experiencing female-factor infertility, it poses both ethical and social challenges regarding the use of another woman's genetic material to create a family. For instance, the use of an egg donor is considered to disrupt biological motherhood as the intended mother (i.e., the infertile woman using the eggs) is not the genetic mother (i.e., the egg donor), challenging Western kinship ideals of hereditability and relatedness (Becker, Butler and Nachtigall 2005, Franklin 2013b, Strathern 1992). Egg donation also poses ethical challenges regarding who should be able to use a donor as well as under what conditions an egg donor should undergo a risky procedure to procure her gametes for another's use (Bayefsky, DeCherney and Berkman 2016, Cattapan 2016a, Heidt-Forsythe 2018, Kenney and McGowan 2014, Marre, Román and Guerra 2017, Ogbogu and Nelson 2012).

Generally, prior to beginning the process, egg donors are psychologically and medically evaluated. This process includes an oral medical history and increasingly involves genetic screening for common heritable conditions that can affect the development of the fetus and a child. If a donor passes these tests and provides informed consent to donate, she will be instructed to give herself hormonal injections for six weeks to stimulate the increased production of eggs, from ten to forty eggs. During the stimulation phase, the donor must attend multiple medical appointments to monitor her cycle through both ultrasound and blood tests. Once these tests suggest that the eggs have matured, an injection of the hormone, human chorionic gonadotropin (hCG) will be used to trigger ovulation. Then, the mature eggs will be removed from the follicles through transvaginal ultrasound aspiration, an outpatient procedure.

Common side effects of the stimulation protocol include abdominal swelling, tension and pressure in the pelvis, mood swings and bruising from the injections. Some women also experience temporary menopause-like symptoms including vaginal dryness and hot flashes. More rare side effects include accidental pregnancy (if the donor does not abstain from sex during the donation period) and allergies to the medications administered (Bodri et al. 2008). In 1-10% of all egg donation cycles, a donor will experience Ovarian Hyperstimulation Syndrome (OHSS). OHSS causes dehydration, fluid retention in the chest and abdomen, and cystic enlargement of the ovaries. If not treated, OHSS can result in hospitalization and even death. The risk of OHSS is highly correlated with the drug protocol; measures such as using a more conservative hormone protocol can be implemented to decrease the risk of OHSS. In 1% of all cycles donors may also experience ovarian torsion, which may result in the loss of an ovary and damage to the woman's future fertility. Some drugs may also increase the risk of ovarian cancer; however, research is not conclusive regarding these specific risks (Stanford University 2002). Complications from the egg retrieval surgery may include injury to the bowel, bladder, uterus, or other structures in the pelvis, infection, future infertility, and/or vaginal bleeding. Some women may experience additional complications that arise from the anesthesia used in the outpatient procedure, and about 1.5% of egg donors will require hospitalization after the procedure (Stanford University 2002).

Although egg donation involves risks during and immediately after the procedure, there is a lack of information surrounding the long-term risks to donation. The lack of donor registries in countries like Canada, the United States, the Czech Republic and Spain prevent clinics from tracking the immediate and long-terms risks of donation as well as the number of times a donor has donated. Since egg donors are generally required to be under the age of thirty-two (Havelock et al. 2016), there is also concern that egg donors may be putting their own fertility at risk in order to help someone else have a child. Unlike surrogacy where many clinics require her to have her own children before acting as a surrogate, the need for young egg donors in order to increase live birth rates, means that many clinics do not require donors have their own children before donating (Wang, Farquhar and Sullivan 2011). The risks to both a donor's overall health and future fertility have led some to be concerned that if money is offered, women may be unduly influenced to donate (Baylis 2018b, Shanley 2002). However, others have suggested that women who donate should be compensated for their time and effort in donating, oftentimes likening egg donation to participating in a research trial and noting both the emotional and physical work of donation (Cooper and Waldby 2014, Curtis 2010, Housefather and Cohen 2018, Marre, Román and Guerra 2017, Motluck 2010, Ogbogu 2019).

A GOVERNMENT'S RESPONSE TO EGG DONATION

In addition to concerns over the ability to unduly influence women to donate their eggs, there is also apprehension surrounding the commodification of women's bodies, gametes, and "life" itself (Radin 1996, Scheper-Hughes and Wacquant 2002). That is, in paying a woman for her eggs, a "price" is being placed on (future) life and women's bodies. Since "life" is often considered "priceless" (Titmuss 1970), the altruistic exchange for eggs is often seen to be the ethically and "morally right" decision as it allows for eggs to be exchanged as "gifts" (see chapter 5). The concern surrounding undue influence as well as the commodification and commercialization of human life has led some countries like Canada to mandate altruistic egg donation so that women are not paid for their eggs.

In light of concerns surrounding the commodification of life and the risks that egg donation posed to women, in 1989 the government of Canada commissioned a group of scientists, philosophers, and medical practitioners to evaluate these social and ethical concerns. This Royal Commission presented the government with a thousand-plus page report. This report would lay the groundwork for the *Assisted Human Reproduction Act (AHRA)*[3], which was first passed in 2004. Declaration 2 of the *AHRA* states,

> The Parliament of Canada recognizes and declares that…. (f) trade in the reproductive capabilities of women, and men and the exploitation of children, women and men for commercial ends raise health and ethical concerns that justify their prohibition;

This declaration included a section which prohibited the "purchase of gametes,"

> No person shall purchase, offer to purchase or advertise for the purchase of sperm or ova from a donor or a person acting on behalf of a donor (Section 7(1)).

Taken together these sections mandated that egg donation exist within an altruistic system where Canadian citizens could not legally buy ova (eggs) could not be legally bought, sold, or traded within Canada. While these rules were and continue to be controversial (see Chapter 2, Baylis 2018a, Housefather and Cohen 2018) they also presume that any market for egg donation would be necessarily exploitative and, moreover, that legislation could effectively curtail the commercialization of gametes and protect those "vulnerable" to the harms that commodification could pose. I propose that when the *AHRA* took an institutional approach to the egg donation market (Fligstein and Dauter 2007), narrowly defining commodification and commercialization, it overlooked the roles of individual actors and global systems in creating markets. In doing so, the *AHRA* and its supporters presumed that in classifying egg donation as a "gift", eggs would not be able to become commodities.

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[3] For a deeper discussion of the process by which the *AHRA* came into place see chapter 2.

In tracing the pathways Canadian fertility care consumers use to find a gamete for use in IVF, I empirically consider cultural narratives surrounding vulnerability, commodification, commercialization, morality/ethics, and family formation in light of national and global legislation (see especially chapter 2) and institutional practices and values (see chapter 4 and 6). I also analyze the effects that these laws have on Canadian medical practices and the care that fertility consumers received (see chapters 4-5). I also consider the role of trust in creating an abroad market for eggs by examining how fertility clinics in Spain and the Czech Republic used cultural capital (Bourdieu 1986, Shim 2010) to signal their trustworthiness as destination sites within the global market for eggs (see chapter 6).

In doing so, I help to bridge the gap between institutionalist and performative understandings of markets (Fligstein and Dauter 2007). Fligstein and Dauter (2007) in their review of the sociology of markets, note that far too often those who study markets from an institutional perspective fail to consider the role of actors in their analyses, creating deterministic accounts of markets that rely on a rule-based method of explanation where laws and regulations guide market interactions. On the other hand, Fligstein and Dauter (2007) claim that scholars who study markets from a performative standpoint (e.g., actor-network theorists) often ignore the role that governments and laws have in determining action. This institutional/performative divide is also present in the sociology of reproduction literature where often scholars analyze specific reproductive laws that drive the accessibility of reproductive technologies and services (e.g., Heidt-Forsythe 2018, McGowan, Cho and Sharp 2013, Pennings, Klitzman and Zegers-Hochschild 2016) or the experiences of users with these technologies (e.g., Bell 2009, Czarnecki 2015, Greil et al. 2017, Hudson and Culley 2011, Luker 1984, Rapp 1999, Thompson 2005). Almeling (2007) has suggested a biological addition to understanding markets where the value of the body is considered in analyzing the markets and use of these technologies. While these studies have pointed to the way that laws affect access and how users experience reproduction, they have largely neglected how the interpretation of these laws have been important in determining the way that fertility care consumers and health care professionals experience and help to create the market for reproductive goods and services.

This oversight may be due to the focus on US health care politics where laws surrounding reproductive care are generally absent (e.g., in the case of assisted reproductive technologies, genetic screening technologies) and/or highly controversial (e.g., abortion laws). Canadian scholarship on the effects that the *AHRA* has had on egg donation has largely been normative in focus (e.g.,Baylis 2012, Baylis 2018a, Baylis and Downie 2013, Baylis and Downie 2014, Cattapan 2013, Cattapan and Cohen 2013, Ogbogu 2019, Ogbogu and Nelson 2012), leaving Cattapan (2016a) to note that there is a lack of information on the effectiveness of the law in "protecting" women from exploitation. Most work in Canada either takes a pro-*AHRA* side calling for an enforcing of the regulations (Baylis and Downie 2013, Downie and Baylis 2013) while other work calls for a set of guidelines that egg donation be treated as work (Cattapan 2013, Cattapan 2016b, Cattapan and Cohen 2013, Ogbogu 2019). This dissertation considers these arguments, providing empirical evidence for the reality of egg donation in Canada. To my knowledge, only two other empirical accounts on Canadian egg donation exist (Hammond 2015, Motluck 2010). While Hammond's doctoral thesis shows the difficulties of finding a truly altruistic donor in Canada and Motluck's *Walrus* article highlights the (mainly negative) experience of egg donors, neither work fully considers the global trade of eggs. Furthermore, both were written before the implementation of frozen egg technologies, a practice which has eased the transport of paid-for eggs across borders. Thus, my work broadens the previous focus of Canadian scholars on *Canadian* egg donation, arguing for a global examination of the *AHRA*.

Scholarship which considers the global experiences of reproductive travel of fertility patients often focuses on the experiences of actors (see Pande 2010, Speier 2016) or the permissive and restrictive laws that guide the practice (for a review see Hudson et al. 2011, Inhorn and Patrizio 2012). While these works recognize the global markets that have been created through patient travel, they do not specifically trace the ways that consumer-demands, medical practices, and policies simultaneously create global markets of care (for an analysis of medical providers and markets in the US, see Martin 2015). Consumers and producers negotiate these markets of care which exist within larger structural systems of biomedicalization (Clarke et al. 2003), capitalism, and gendered constructions of motherhood (Franklin 2011). This dissertation examines the material and moral consequences of the developments of these markets using recipient[4] experiences and fertility care professionals' perspectives.

LITERATURE REVIEW

Assistive reproductive technologies and motherhood

Research on the experience of infertility has been the work of social scientists, bioethicists, and medical practitioners. Social scientists are often concerned with the effect that infertility has on women's conceptions of self, showing how infertility poses mental health challenges such as increased stress and decreased quality of life (Greil et al. 2011a, McQuillan, Torres Stone and Greil 2007, Ramírez-Uclés, Castillo-Aparicio and Moreno-Rosset 2015,

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[4] I use the term recipient to describe the woman who asks for and/or purchases the egg. Some egg donation literature uses the term intended parent. I choose not to use this term as some of the women who I interviewed had already become parents using egg donation. I will also use the term fertility traveler to describe those who travelled for egg donation.

Verhaak et al. 2007). This work has also highlighted the stigma that infertile women and men face in light of the inability to have children (Whiteford and Gonzalez 1995). For women, there may also be a sense of shame as they are no longer able to fulfill their biological duty of being female (Jansen and Saint Onge 2015). These feelings of stigma and stress due to this disruption of the life course have been tied to traditional gender roles where women are expected to become mothers (Greil 1997). These perspectives often suggest that individuals should be provided with counseling and support services to increase their quality of life as they navigate fertility treatment and to help them reconcile the identity disruption they may face in light of treatment (Boivin 2003, Dawadi, Takefman and Zelkowitz 2018, Domar et al. 2015, Kahlor and Mackert 2009). While some of this literature points to the role that stress may play in contributing to infertility, a recent meta-analysis has shown that stress is more likely a consequence of infertility rather than a cause of infertility (Nicoloro-Santa Barbara et al. 2018).

In treating infertility and the consequences of infertility as a medical diagnosis that can be treated through the use of drugs and therapy, infertility has become increasingly medicalized (Becker and Nachtigall 1992). The medicalization of infertility has both positive and negative consequences. For example, in thinking about infertility in terms of a medical diagnosis rather than a failure to achieve parenthood, medicalizing infertility can provide couples ways to achieve parenthood while also providing them with medical language to describe their condition (Johnson and Fledderjohann 2012). However, others have noted how advances in reproductive technologies and the widespread availability of (expensive) treatment have also placed pressure on women to continue to try to become mothers (Franklin 2013b, Sandelowski 1991, Thompson 2001). Sandelowski (1991) describes the ever-availability of assisted reproductive technologies and the promises that they hold for motherhood as creating a “never enough” culture where women continue to try to conceive through the use of ARTs regardless of the financial and emotional costs.

This “never enough” (Sandelowski 1991) culture of infertility often aligns the potential mother as the consumer, who actively chooses reproductive technologies to both overcome the medical “disease” of infertility, while simultaneously demanding that fertility patients make certain choices such as which clinics to go to, which treatments to use, and how many treatments they desire. While the consumption of technologies to overcome infertility may challenge traditional definitions of medicalization (Martin 1987, Oakley 1984), as the woman is no longer a passive recipient of medical care (Taylor 2004), it also helps to create “anxious reproduction” whereby prospective parents (especially women) are confronted with both the (seemingly) widespread availability of reproductive technologies as well as a culture of “intensive” parenting strategies (Faircloth and Gürtin 2018:985). “Anxious reproduction” may help explain the desire to continue to pursue expensive reproductive fertility treatment even in the face of multiple failures, the numerous online discussions surrounding what treatment options to try and what clinics to attend, and the copious amount of time and money that recipients spend pursuing parenthood. It also may help explain why women in the face of deciding between stopping treatment, using an egg donor, and or adopting, many women choose a phenotypically similar egg donor (Becker, Butler and Nachtigall 2005, Marre and Bestard 2009). This choice allows women to carry and give birth to a baby who has a higher chance of resembling them, allowing for continuity in familial resemblance (Strathern 1992).

Egg donation, while challenging biological motherhood, allows for an individual woman to experience the pregnancy and birth of her child, offering an experience that one cannot have with adoption. Previous studies have shown that women who choose egg donation often do so because of the desire to control the pregnancy and childbirth experience (Hammond 2018). Some women even report the potential epigenetic effects that carrying the child could have; sometimes conflating the ability of the pregnancy environment to impact genetic expression with the ability to become biologically related to one's child (Franklin 2013b, Payne 2016). These narratives help to soften the potential challenge that egg donation has on biological motherhood while simultaneously positing that egg donation is the "next best" option. However, egg donation, while it offers the experience of pregnancy, is not readily available in all countries and is a costly procedure (~$8,000-$85,000 CAD), limiting the ability for all women to access these technologies and experiences of birth. Thus, those who pursue egg donation are generally upper-middle class white women who have both the financial resources and cultural capital to navigate complex systems of fertility care (Bracewell-Milnes et al. 2016).

Cross-border reproductive care

National and international regulations that vary from country-to-country affect these systems of fertility care (Martin 2009, Pennings, Klitzman and Zegers-Hochschild 2016). For example, in some countries, like the United States, there is no limit on the amount of money an egg donor can be compensated, while in other countries, like Canada, the amount of compensation is limited to reimbursable expenses[5] (*Assisted Human Reproduction Act* 2012). Furthermore, some countries, like the Czech Republic and Spain, have laws that prohibit payment, but have liberal compensatory practices (*Czech Republic Act on Research on Human Embryonic Stem Cells and Related Activities [Translated]* 2006, *Spanish Royal Decree 42/2010 of January Which Regulates the National Commission for Assisted Human Reproduction*

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[5] Reimbursable expenses are not defined in the current *AHRA*, but are generally considered expenses that are related to the process of donation such as the medications needed by the donor and her transportation to and from the clinic.

[Translated] 2010). While this disparate regulation allows for individual countries to decide upon laws surrounding egg donation in ways that may reflect specific country values (e.g., Germany prohibits egg donation, largely because of its history of eugenics) (Pennings 2004), it also means that some individuals have access to egg donation while other individuals have no or little access. The practice of cross-border reproductive care (CBRC), or the movement of fertility patients from one country to another, is most common in Europe with a minimum of 11,000-14,000 patients per year seeking fertility care outside of their home country (Shenfield et al. 2010). While this process has been less well-documented in Canada, a survey of 34 Canadian infertility clinics found that six percent of infertile women (445 out of 6,927) seek IVF in another country (Hughes and DeJean 2010). Approximately 80% of these women were in search of anonymous donor eggs (oocyte donation), and most of these women travelled from British Columbia (42%), Quebec (8%) and Ontario (50%) to the United States, Latin America, or the Czech Republic for treatment (ibid). In another survey of 28 patients who had received fertility care in another country, patients reported traveling from Canada to the United States, Mexico and the Czech Republic for treatment (Blyth 2010).

Some have argued that cross-border reproductive care (CBRC) allows for moral pluralism as individuals are able to choose the reproductive services that align with their own personal moral values (Pennings 2002). However, others have suggested that this movement of fertility patients has result in “reproductive exile” where infertility patients are not able to access the services in their home countries that they may medically need to form their families (Inhorn and Patrizio 2009). They have criticized the use of the term “tourism” as it implies that individuals are travelling for fun, pointing out that most reproductive travelers would prefer to stay in their home country to receive the care that they need (Mattoras 2005). In this framing of cross-border reproductive care, infertility is positioned as a medical condition, whereby the lack of available treatment in some areas is considered a failure of the home country's medical system (Daoud, Ghent and Sherron 2015). CBRC[6], thus, represents the inability of individuals to access affordable medical treatment, following historical trends of women's lack of access to reproductive services (e.g., abortion, contraception) (Mattoras 2005).

Some of the lack of access to fertility services is due to high costs of treatment in their home countries (Culley et al. 2011). In this regard, traveling for fertility care mimics other types of medical tourism where individuals travel to other countries because they cannot afford medical treatment in their home country (Deloitte Consulting 2008, York 2008). This trend of international patients seeking care in more affordable places represents a change in the industry of medical tourism (Carrera and Bridges 2006). In the past, medical tourists often traveled to places (e.g., North America) for technologically-advanced care that they could not receive in their home country. However, increasingly lower-income countries are attempting to attract international patients through their use of high-tech treatments and surgeries at far more affordable prices. The slogan "first world health care at third world prices" is often used to emphasize the presence of US-board certified physicians, create a network of global clinics, and standardize their clinics through international accreditation, creating a reputation for these international clinics (Turner 2007). Thus, these clinics become credible and affordable sites for international patients looking to receive affordable and timely health care.

Further enhancing the attractiveness of these clinics are the additional amenities these clinics provide. Massage therapies, five-star hotel room accommodation, access to expert

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[6] In this dissertation, I use the term cross border reproductive care to describe the general practice of traveling for care. I use the term "fertility tourism" to describe particular traveling experiences as my respondents often coupled their reproductive travel with an extended vacation.

medical care, transportation services, and meals from popular local restaurants provided to patients create an option of treatment that is simultaneously more affordable and more luxurious. For Canadians, the lure of these clinics includes not only the shorter waiting times, but the ability to take side trips and stay in luxurious hotels while receiving prompt and private “concierge” medical treatment that does not exist within the national health care system (Turner 2007). Thus, travel for medical care not only becomes about the type of care one receives, but also involves choosing between different types of services offered.

Sometimes in Canada broker companies, who serve as the middle-person between the patient and the country of care, facilitate this choice. These facilitators specialize in finding a private clinic and arranging the patient care and travel (Johnston et al. 2011, Snyder et al. 2011). While these facilitators often see themselves as upholding a high ethical standard, ensuring the patient receives the best possible care, the lack of Canadian regulation means that facilitators are not held legally responsible for substandard care (ibid). While facilitators are available, Turner (2011) notes that about 50% of these companies have recently disappeared. This disappearance could be due to the limited role facilitators have in arranging patient visits abroad and the ease with which consumers can personally contact the international private medical clinic via web pages and email. In her ethnography of CBRC to the Czech Republic, Speier (2011) notes how the broker who once guided North American fertility patients is increasingly being replaced as fertility travelers use webpages and fertility forums to find information on clinics and book fertility travel. Thus, the ease with which potential medical consumers can plan their trips from their homes, may mean that traveling becomes a realistic option for couples facing legislative restrictions, high costs, and/or long wait times. This globalization of infertility services, Martin

(2009) argues, allows for individuals to consume reproductive services while simultaneously posing questions of justice in the context of needs versus desires.

While the ability to travel across borders for fertility treatment may allow some women to gain access to services that they may otherwise not have, it also raises questions surrounding the exploitation of women for their eggs and wombs. This concern stems from the differences in social class standing of the intended parents/recipients and the surrogates/egg donors (Pande 2014, Pfeffer 2011). Since travel for reproductive services often happens from richer nations to poorer ones, the ability to exchange money for eggs and wombs may allow for the exploitation of poorer women who have few options for work and see the money as a way to support their families (Gupta 2012). While some have called for the global banning of payment for egg donors and surrogates, others have called for increasing regulation surrounding the use of egg donors and surrogates, seeing egg donation and surrogacy as a legitimate (albeit neo-liberal) choice for women who face economic hardship (Pande 2014). Survey evidence supports the argument that egg donation is not entirely exploitative, suggesting that in countries where egg donors are compensated “altruism” (47.8%) and “altruism as well as financial” (33.9%) are the major reasons that donors donate compared with “financial only” (10.8%) (Pennings et al. 2014). This survey of eleven European countries also shows that about half of all egg donors are fully employed (49%), suggesting that egg donation may not be purely reliant on an exploitative market. However, the results also showed that as compensation increased relative to the donor’s purchasing power in her country, the donor was more likely to report donating only for financial reasons (ibid). Thus, a limit on compensation may be necessary to prevent against the coercion of donors (Steinbock 2004).

While surrogacy has been criticized for the use of poor colored women's bodies to create babies for wealthy white couples (Gupta 2012), recipients in search of egg donation are often in search of donors who resemble them (Martin and Kane 2014). Eggs and the locations they come from become racialized as "white" and "non-white." Countries who can offer more "white" donors are then often seen as preferable for patient travel as the clinics can guarantee that they will have a donor that matches the characteristics of the traveler. For example, Speier (2016) shows how recipients of egg donors choose the Czech Republic because clinics could promise them a child that resembled them. This resemblance is often sought after in order to manage comments surrounding the child's lineage. In using a donor who has the same skin color, eye color, and hair color as the recipients, the chance that the child will look like its parents increases. Resemblance is important, Bergmann (2011) argues because it allows for the "passing of kinship", minimizing the appearance that the recipients used technology to achieve what is supposed to come naturally. Thus, the travel to countries like the Czech Republic and Spain where there is availability of white donors becomes a way that recipients can mimic traditional kinship (Wong 2017).

Kinship and Genetics

Achieving pregnancy through the use of another's gametes challenges ideas surrounding kinship in that relatedness must be redefined outside of blood or genetic lines (Edwards 1999, Franklin 2013b, Strathern 1992). Previously euro-western notions of kinship relied on the concept of blood ties carrying familial lines of relatedness (Strathern 1992). This system of relationship allowed for a historicization of the family in which individuals trace their blood line to establish their connections through time (Harrington, Becker and Nachtigall 2008). In these traditional familial structures, belonging was conceptualized through “bodily materiality” (Cepaitiene 2009) in which familial relationships were directly tied to “blood.”

IVF creates the possibility for familial relationships to exist outside of these “blood” relationships. For example, the use of an egg donor to achieve pregnancy may mean that the child has a different biological mother (in terms of origin of the egg), social mother (in terms of who will raise the child), and gestational mother (in terms of who will carry the child to term). The possibility for familial relationships beyond biology changes notions of kinship as kinship is no longer tied to biological reproduction (Franklin 2013b, Ragoné 1998). ARTs challenge traditional familial structures, defamiliarizing what was once considered the “natural” basis of human creation (Ragoné 1998:118). Thus, while the family is no longer rooted entirely in notions of biology, the “natural” conception of the family is not lost, only modified.

Clinics, thus, work to make IVF seem like a natural technology (Cussins 1998) in which people choose to pursue families. Part of this naturalization is the use of phenotypically similar donors as these donors allow for the illusion of relatedness (Nahman 2013). Phenotypic matching allows for families to more easily hide the fact that their child was conceived through technology, providing an illusion of naturalness, in favor of having a child. Phenotypic similarity also becomes important as families choose whether or not to tell their child how they were conceived (Wong 2017). While most psychosocial literature suggests that donor-conceived individuals are better off being told about how they were conceived, some families[7] will choose to keep the donation a secret (Ilioi and Golombok 2015). The lack of disclosure is often attributed to a fear that if the child is not genetically related to one or both of its parents,

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[7] Since families are not required to follow-up with clinics after the birth of their child, there is no statistical data on how many families choose not to tell their child.

outsiders and potentially the child itself will not be considered part of the family. Thus, parents who use donor gametes actively manage the information that they both provide their child and others surrounding them, relying on discourses of resemblance, in order to maintain familial unity and the perception of relatedness (Becker, Butler and Nachtigall 2005). Although some have argued that the use of reproductive technologies has served to reinforce rather than transform current familial structures (Thompson 2005), others have shown that new reproductive technologies may break down kinship boundaries, creating a possibility for de-naturalized reproduction where families are based on social rather than biological ties (Edwards and Salazar 2009, Haraway 1991, Mamo 2007). However, as donor-conceived individuals look to connect with their biological siblings through the use of donor registries, biology remains an important consideration in determining one's familial relationships. Thus, donor families pose challenges both to the biological and social definitions of families as mothers may have no biological connection to their offspring and donor-siblings may not share the same cultural practices or even language (Cahn 2013).

Biomedicine in donation

Fertility counselors have increasingly been called upon to help families negotiate disclosure to their donor-conceived children. Oftentimes, medical organizations now recognize these counseling sessions as "best practices" (see Blyth 2012, Havelock et al. 2016), and clinics, thus, sometimes mandate these sessions before a recipient goes through with donation. These counseling sessions are supposed to uncover the recipients' motivations for using a donor and guide patients towards a decision to disclose to a child. In cases of known donors, the counselor often meets with the donor alone to ensure informed consent and then again with the donor and the recipient(s) to confirm that everybody has the same understanding regarding the responsibilities of each party and the relationship that the donor will or will not have with the potential future child and/or family (Goedeke, Daniels and Thorpe 2015)[8].

While counseling sessions may be seen as recognizing the psychosocial aspects of fertility treatment with donor gametes, they also serve to reinforce the idea that egg donation is *not* the normal way to build a family. Same-sex couples and single women have been particularly critical towards these sessions, pointing to the heteronormative sessions focus on disclosure and the “giving-up” of one-partners’ genetics (Hayman et al. 2013). Both heterosexual and same-sex couples also point to the expense of these sessions and question the ability for one session with an often unknown counselor to fully discuss the complexities of donation (Visser et al. 2016). Instead many couples refer to these sessions as “tests” or “hurdles” that they must overcome to pursue their family.

While the inclusion of counselors as a routine part of donor conception may help many families make decisions of whether or not to use a donor, it also represents the increasing biomedicalization of infertility. Biomedicalization is the “increasingly complex, multisited, multidirectional process of medicalization, both extended and reconstituted through new forms of highly technoscientific medicine” (Clarke et al. 2003:161). The use of counselors in donor conception represents a new site of medical intervention whereby the act of disclosing to a child and the uncertainty that one may face in light of using another’s gametes can be remedied through a one-time counseling session offered by a certified practitioner. Infertility is first seen as a problem that can be overcome through a medical intervention (i.e., the use of in vitro fertilization with donor gametes) rather than a redefinition of the social (i.e., choosing adoption

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[8] The agreements reached during these counseling sessions have not been tried in Canadian courts; therefore, the contracts created are informal and unbinding.

or childlessness). Then, a counseling session can “fix” the psychosocial consequences that arise because of the discontinuity in kinship (created through the use of another gametes). Thus, infertility has become a fully biomedicalized phenomenon whereby both the medical and psychosocial state of infertility can be treated.

Technological and psychosocial services can be delivered to the patient (increasingly viewed as the consumer) who can individually choose how, when, and where to be treated. As previously discussed, these individual choices become intertwined with gender ideals of motherhood; whereby, the choice to not to try is often deemed as a failure of femininity or masculinity (Sandelowski 1991). The imperative to try has helped increase the demand for fertility services, creating a multi-billion dollar global industry whereby consumer choice for the biomedical solution to infertility (and thus femininity) is offered for a price (Spar 2006). It is within this gendered biomedicalized context that the *Assisted Human Reproduction Act (AHRA)* was passed.

This dissertation examines the biomedicalized experience of infertility under the *AHRA*. The *AHRA*, which limits gamete donation through the prohibition of payment, attempted to limit the practice of egg donation so that the “commercialization” and the “commodification” of life would be restricted and the vulnerability of potential donors would be protected (*Assisted Human Reproduction Act* 2012). However, these limits conflict with the moral imperative to have children and the idea that one can and should use all technologies available to her to achieve that goal. As a result, individuals who could not achieve pregnancy with their own gametes were still offered IVF with donor eggs, regardless of the availability of an altruistic donor (Hammond 2015). Thus, those individuals who wanted to pursue treatment found ways of doing so by either using an altruistic donor, circumventing the law through traveling abroad or by importing eggs from the United States. This study traces these pathways paying particular attention to the material and moral consequences of these pathways. By material consequences, I mean the ways that medical care was provided, sought after, and received in Canada and abroad, contributing to the globalization of fertility services. The moral consequences are the ways that these seemingly individual actions of freely receiving or purchasing eggs are transforming how bodily products are defined and how vulnerability is conceptualized.

DEFINITION OF TERMS

Many of the debates surrounding the ability to exchange and purchase eggs, stem from concerns surrounding commodification and commercialization as well as a desire to protect vulnerable populations from coercion. The *AHRA*'s principles (see Appendix A) highlight these concerns; however, the definitions of commodification, commercialization, vulnerability and coercion are missing from the "Definition" section of the act. Although the *AHRA* provides a definition section to define such terms as "ovum", "sperm", "surrogate mother", and even "Minister", these nonmedical terms were not defined in the law. Thus, different moral actors who engaged with reproductive technologies could (and would) be differentially interpret these terms. This study is concerned with the definitions of these terms and their implications on medical practices involving egg donation. In this section, I define how the Royal Commission, the interdisciplinary body assigned by the government to highlight the social and ethical concerns regarding ARTs, conceptualized each term, and contrast this to existing sociological and bioethical debates surrounding the use of these terms.

Vulnerability

The Royal Commission defined "vulnerability" as relating to power imbalances that "concern the welfare of children" and "arise from a person's socioeconomic status, membership in a minority group or disability" (1989: 55). This report argues that "safeguards exist to ensure that adults who are temporarily or permanently unable to make competence decisions are not ignored or taken advantage of" and that "society also has a responsibility to ensure that vulnerability is reduced where possible and that those who are vulnerable are not manipulated or controlled by those in positions of power or authority" (ibid). While the definition of vulnerability that the Royal Commission provides varies in terms of who is defined vulnerable (i.e., specific groups of people rather than something that is inherent to the human condition, see Fineman 2008), the role of the government to protect vulnerable persons (see Kohn 2014) helps to provide rational for the creation of the *AHRA*.

Vulnerability theory has been criticized for being overly paternalistic and for categorizing certain persons as necessarily vulnerable and in need of protection regardless of context (Kohn 2014, MacKenzie 2013). For this reason, the Government of Canada (2008) redefined vulnerability in research to better understand the "dynamics" that occur in "specific" settings rather than predefining "vulnerable" groups such as socioeconomically disadvantaged women that are automatically deemed "in-need of protection" (Abbott et al. 2008, Levine et al. 2004). However, while this definition is applied in recruitment for research trials, the definition of vulnerability used in the *AHRA* has largely remained stagnant. So while a more encompassing definition of "vulnerability" would allow for a recognition of universal vulnerability and an analysis of situational factors that produce vulnerability (Gilson 2013), the *AHRA* still defines "woman" and "children" as vulnerable populations in need of protection.

The *AHRA* named certain groups of women and children "vulnerable," taking a narrow approach to vulnerability which sees certain populations in need of protection. In this study, I use a more expansive definition of vulnerability that seeks to recognize the way that multiple people can embody vulnerability in multiple forms, depending on circumstance. I argue that laws that want to provide protections for vulnerability should focus on positive rights, allowing for informed consent and autonomy in decision making, rather than restricting practices based on a predefined definition of vulnerable populations. This definition allows for an approach to informed consent and decision making that is cognizant of both power relationships and social structures that may differentially produce vulnerability depending on the context (see also Miner 2017).

Informed Consent, Coercion, and Undue Influence

The *AHRA* states that “the principle of free and informed consent must be promoted and applied as a fundamental condition of the use of human reproductive technologies” (*Assisted Human Reproduction Act* 2012:Section 2d). Informed consent, although not defined in the *AHRA*, traditionally relies on three different validity criteria—intentionality (purposeful action), understanding, and autonomy (Faden and Beauchamp 1986). In assessing informed consent, a person must ensure that the consenting party (in this case the recipient or the egg donor) fully understands the risks and benefits to the procedure. An informed consent process aims to ensure that the individual both understands the risks and benefits and makes a decision independent of controlling influence. Thus, external pressures such as coercion, manipulation, and persuasion ought to be absent from the decision. Most simply informed consent means the ability to make an autonomous decision in light of understanding of the risks and benefits of the procedure.

Often when discussing the ways that women can be influenced in their decisions to become egg donors, the word coercion is used to describe how money may be used to influence the decision. Coercion, however, has a particular meaning in bioethics: the irresistible threat of unavoidable harm that usually involves force or the perception of force (The National

Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979). Within this more narrow definition, it is unlikely that money could be a coercive element in obstructing informed consent as the offer of money does not generally constitute a threat (Largent et al. 2013). Instead, the promise of money for donation could be seen to unduly influence the donor to donate, that the donor was overlooking the risks of donation in favour of receiving the compensation. In this study, I will use the term undue influence to refer to the possibility that individuals may make different decisions if money is present. However, some of my respondents used the word "coercion" to describe money's influence on potential donors' decisions. In these cases, I will use the participant's original words, noting that the use of coercion in this manner conflates force and influence.

Commodification and Commercialization

The *AHRA* uses the words "commodification and commercialization" to explain why the "trade in" eggs should not be allowed (see section 3). Although these words have different meanings, commodification meaning the process of economically valuing an object (Appadurai 2013 [1983]) and commercialization as process of turning something into profit/putting it on the market, the act does not address this difference, potentially conflating the meanings of these two words. For the Royal Commission (see page 111 of the report), commodification is used with regard to placing a value on a future child through "preconception arrangements" where payment is offered either to the gestational mother in cases of surrogacy or to the egg donor. Oftentimes, a broker is used although the commission notes that private arrangements can also be made. This definition of "commodification" describes the "commercial" relationship that is formed when a set payment is given in exchange of an egg and is contrasted with non-commercial arrangements whereby the woman receives payment to cover personal expenses (665). Commodification is thus used to describe the changed social context in which the egg has become commercial, offered up for sale.

In both the report and the *AHRA* both commodification and commercialization are given the connotation that these processes are necessarily morally wrong, disrupting the "sanctity of human life" (Zelizer 2005). The way to prohibit the commodification and commercialization of life (in the form of an egg) was seen through the prohibition of payment. Although the Act and the Royal Commission assume that commercialization and commodification can and should be prohibited by mandating altruistic exchanges, through this study I interrogate the material and moral consequences of these assumptions, highlighting the ways that eggs continue to be commodified.

RESEARCH OBJECTIVES

The overarching aim of this thesis is to investigate the material and moral consequences that arose from mandating altruistic exchanges for eggs. I do this by tracing the pathways Canadians use to find eggs and interviewing the fertility practitioners, who have become in charge of their care both abroad and at home, about their practices. My specific questions are formulated in light of the availability to travel and ship eggs across borders, recognizing the need for a global analysis of the consequences of egg donation. The following related research questions guided my dissertation:

1. How do various stakeholders including physicians, nurses, counselors, lawyers, and recipients respond to a law that restricts the practice of egg donation?
2. How does the *AHRA* shape the moral economy of egg donation? What is the effect on the organization structure of egg donation in Canada and abroad? Does the presence of other

laws (i.e., the Spanish and the Czech law) within a global system of egg donation create different moral consequences?

3. What are the organizational and institutional factors that allow for the purchasing of eggs within Canada and abroad?

I use 98 in-depth semi-structured interviews with various Canadian and abroad stakeholders including recipients and fertility care professionals to answer these questions. To capture the experience of traveling to another country for care, I traveled to these destinations to interview the fertility clinic staff. I also performed content analyses of brochures and websites. My methodological framework and data collection strategies are outlined in more detail in chapter 3.

OVERVIEW OF THE CHAPTERS

Debates in Canada surrounding egg donation tend to focus on the normative question of whether or not eggs *should* be commodified. In this dissertation, I examine the empirical reality of egg donation in Canada, ultimately arguing that a dualistic view of eggs as either commodities or gifts does not fully capture the way that eggs are currently donated and exchanged. Acknowledging that commodification of eggs is already occurring through the shipment of frozen eggs from the US to Canada, travel across borders for egg donation, and payment happening under the table in Canada, I focus on the discourses that are used when eggs are sold but not purchased. "Not bought but sold" refers to the ways that fertility professionals and fertility patients negotiate the *Assisted Human Reproduction Act's* prohibition on payment by using national borders and agencies to separate the act of paying an egg donor from purchasing an egg in order to "comply" with the act.

Before I introduce my empirical data, in chapter 2, I outline the different legislation, which affected the practice and receipt of egg donation both in Canada and abroad. I use the framework of bioethical complexes to better understand how global policies interacted with one another to allow for Canadian patients to travel for egg donation. This chapter serves as the basis for my data collection choices in that it shows the macro-forces by which the Czech Republic and Spain became destinations for Canadians looking for donor eggs. I place this chapter before the description of my methods as it helps to justify my choices of traveling to these countries to better understand the context of cross-border reproductive care. This chapter also provides a more in-depth exploration of the *Assisted Human Reproduction Act (AHRA).*

The next chapter outlines my methodological framework, and my data collection and analyses strategies. My work is grounded in feminist empirical bioethics. By this I mean, I take a critical approach to the ways that power, stemming from a patriarchal worldview, affects women's bodies and lives. I use empirical data to critique these power structures and to develop normative claims on how egg donation *ought* to be viewed. While much sociological work often fails to take a normative stance, the policy-oriented nature of my work places me in a position to critique and offer suggestions on how policies and practices can be reformulated to better serve those who are affected by these technologies. A feminist approach also requires reflexivity at all stages including the conceptualization, enactment and formulation of my research. I see an abductive analysis strategy, a process that combines both inductive and deductive analysis (Tavory and Timmermans 2014), as allowing me to reflect upon how my own social position, including the sociological, bioethical, feminist, and science and technology studies' perspectives that have shaped me as a scholar, affect my interpretations of my data.

It is these multiple perspectives that made it challenging for me to write chapters that seamlessly flowed together. Although each chapter is framed using different theoretical and empirical work, they all sit together to illuminate the multiplicity of experiences of recipients and professionals who are all part of a globalized marketplace of reproduction.

My first empirical chapter (chapter 4) focuses on the Canadian fertility care professionals, including the lawyers, counsellors, egg bank coordinators, nurses and physicians who come into contact with Canadian fertility patients in need of egg donation. I examine how professional authority and hierarchies of physicians are maintained through interactions with social structures (e.g. the law and national borders), and other fertility professionals who have varying degrees of power. After the passing of the *AHRA*, egg donation in Canada was challenged. This chapter illuminates how medical professionals responded to that challenge using boundary-work (Gieryn 1983), shifting the ethically and legally contentious work to their patients and other fertility professionals. The ability for the medical profession to continue to practice egg donation and to define this practice as ethically "good" despite debates illuminates how medical professionals respond to laws that attempt to restrict their practices. A version of this chapter was published in *Social Science & Medicine* (see Miner 2019).

In chapter 5, I more fully uncover how recipients, counselors, and lawyers understood the practice of egg donation. Using their perspectives, I show how the Canadian legislature through its criminalization of the market for eggs has oversimplified the relationship between gift exchange and commodity exchange such that the material and moral consequences of market limits placed on these exchanges has largely been overlooked. I show how counselors, recipients, and lawyers understand and conceptualize these exchanges outside of the gift/commodity dichotomy, often aligning the ability to exchange money for eggs as the ability to pay a labourer for her work.

I then move to two markets where money is exchanged for the work it takes to produce those eggs, the Czech Republic and Spain. One consequence of this ability to exchange money for eggs has already been established: there are more donors in these two countries than in other countries. The large number of donors has previously been shown as helping the two countries create markets for patients, like Canadians, who have restricted access to egg donors in their home countries. I investigate these two markets further, exploring their use of cultural health capital (CHC) (Shim 2010) to attract patients to their clinics. In applying CHC to fertility travel involving fertility clinics located outside of North America (i.e., the Czech Republic and Spain), my research specifically highlights the ways that fertility professionals in their interactions with foreign clients must manage language and cultural differences while signaling their clinic's efficacy and safety to be perceived as a suitable clinic for patient travel. By examining how fertility clinics embody and institutionalize CHC, I highlight the importance of CHC in patient-professional interactions that happen across borders. I also show how successful implementation of CHC can be used to further increase the success of the fertility clinics in a global marketplace while continuing to stratify who has access to this care. While CHC is often used to conceptualize how existing social inequalities are reproduced on the level of the patient (see Dubbin, Chang and Shim 2013 and Gengler 2014), I broaden its application to examine how markets are created, illustrating how some countries are able to become "receiving" countries for patient travel. Cultural and economic resources of the travelers further stratifies reproduction as only those who can afford to travel and have the knowledge to navigate the global marketplace are able to interact in this marketplace catered to their specific needs.

In my concluding chapter, I more fully examine the ethical implications of Canadians traveling overseas and importing frozen eggs for their use. I provide recommendations surrounding how the law could be changed to both recognize the labour that is put into creating eggs while also ensuring that egg donation does not become exploitative. Overall, my research offers empirical evidence surrounding the limitations to the current *AHRA*, illuminating how the practice and receipt of commercialized egg donation continues to occur inside of a globalized market for eggs. I explore how individuals conceive of ethics within these different marketplaces while complicating the idea that this marketplace is necessarily ethically wrong.

Chapter 2

Pathways to Eggs: The biopolitical landscape of egg donation in Canada, the Czech Republic and Spain

As assisted reproductive technologies (ARTs) became standard treatment for infertility in the late 1980s, governments attempted to regulate their use. Approaches ranged from policies that minimally regulated ART use (e.g., the United States) to policies which severely restricted the types of treatments available to its citizens (e.g., Germany). While these regulations were disparate, all attempted to protect the users of these technologies, including the infertile couples using ARTs and the potential donors of reproductive materials. Almost uniformly, governments tried to uphold the "sanctity of human life" by preventing such "evils" as human cloning, and the transmission of certain diseases (e.g., AIDS) (Attorney General of Canada v. Attorney General of Quebec 2010). In defining some aspects of ARTs as "evil" (e.g., cloning) and others as "good" (e.g., access to alternative forms of family building), governments across the world engaged in biopolitics.

This chapter focuses on the biopolitics surrounding the creation of the Canadian *Assisted Human Reproduction Act (AHRA)* and how this biopolitical framework exists within a global bioethical complex of assisted reproductive technologies (ARTs). I focus specifically upon Canada's biopolitical framework in relationship to the biopolitics of two EU countries, the Czech Republic and Spain. I have chosen to examine the biopolitics of these three countries because of the ways their egg donation systems have become intertwined through bioethical "complexes" (Rabinow and Rose 2006), which have created a system of "sending" (i.e. Canada) and "receiving" countries (i.e., the Czech Republic and Spain).

The term "biopolitics" refers to the "specific strategies" regimes of authority (e.g., governments) use to attempt to regulate human life through various forms of biopower (Foucault 1978, Rabinow and Rose 2006:197). According to Foucault (1978), biopower is the use of various techniques and discourses, including laws, in order to exert control on the body. Biopower is often exerted to protect the "'vital' character of living human beings" (Rabinow and Rose 2006:197). What is considered "vital" is based on current "truth discourses" such as national regulations, which determine what is considered human life. Biopower often relies on "bioethical complexes," or the combination of regulatory bodies, government commissions, and legislation, to exert its power (Rabinow and Rose 2006:203). In the case of ARTs, biopower is often exerted through national laws as "strategies of intervention" to prevent some ART practices while still allowing for others. These laws (imbued with biopower) are intended to uphold current understandings of life—in this case the (re)production of life (Rabinow and Rose 2006:203).

One vital discourse these bioethical complexes uniformly wanted to preserve was the "sanctity of human life" (Zelizer 1979), the inviolability of human life. Thus, various laws were created to prevent the commercialization and commodification of human gametes (i.e., sperm and eggs). This chapter outlines the ways in which Canada, the Czech Republic and Spain, have enacted two different types of biopower surrounding the compensation of egg donors to prevent against the commodification of reproductive gametes and to protect vulnerable (i.e. young socioeconomically disadvantaged) women from harm. In Canada the legislation *restricts* compensation of donors while Spain and the Czech Republic's legislation *regulates* compensation. These two types of biopolitics have different consequences for global reproductive health and the pathways recipients can use access ARTs.

These variations in consequences and pathways, I argue, is dependent on how each region conceptualized who was considered a moral agent[9]. I show how the Canadian *Assisted Human Reproduction Act* (*AHRA*), by using the words “no person shall,” created expectations of *individual* citizens to abide by the regulations (*Assisted Human Reproduction Act* 2012, s7). These expectations created a bioethical complex that regulated citizens rather than institutions. In contrast, the Czech and Spanish law implicated *institutional actors,* fertility clinics. I show how these two different conceptualizations of moral agents renders different degrees of moral and legal responsibility for those involved in egg donation (particularly those seeking donation). I argue that Spain and Czech governments, by defining who is considered a moral agent (i.e., the fertility clinics), created a system whereby biopower is explicitly enacted, overt biopower. In contrast, the Canadian law, by not specifying who is responsible, creates a system whereby punishment is uncertain, but biopower is still present, covert biopower.

In this chapter, I present the global biopolitical context which has shaped the practices of egg donation in Canada. The context that I describe provides the background for my methodological choices and my empirical chapters. Since this study uses Canada as a case study for how restrictive legislation operates in the global market of reproduction, I first outline the Canadian biopolitical context detailing the ways the *AHRA* was developed and contested. In describing the consequences of this legislation, I explore the factors by which Canada has become a “sending country” for intended parents searching for an egg donor. I then show how the Czech Republic and Spain have become “receiving countries.” I first outline the larger

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[9] a person or a group of persons who has the ability to discern right from wrong and who holds responsibility for their actions

biopolitical context which guided these two countries' regulation, the European Union Tissue and Cell Directive[10] (European Parliament and Council Directive 2004). Next, I provide a description of the laws in the Czech Republic and Spain detailing how these bioethical complexes have made these two countries popular sites of reproductive travel. Finally, I describe the pathways that Canadian intended parents may take in order to find an egg (figure 1). The global biopolitics of egg donation determines these pathways.

THE CANADIAN CONTEXT

In 1989, the federal government of Canada tasked a Royal Commission on New Reproductive Technologies ('Royal Commission' or 'the Commission') to evaluate the "social, ethical, health, research, legal and economic implications" of ARTs (Chenier 1994). The Commission was an interdisciplinary team of researchers, physicians, lawyers, academics and activists who were asked specifically to weigh the benefits (i.e., the ability to help families and individuals create families) against the potential harms to health, and well-being (e.g., ovarian hyperstimulation syndrome[11] (OHSS), multiple pregnancies, costs of treatment, negative psychosocial outcomes, coercion of donors). This final report, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies* (1993), based on interviews conducted with experts and Canadian citizens, provided three conclusions: 1) that there was a need to define boundaries of assisted reproductive technology use; 2) that these boundaries should be stated by "accountable regulation"; and 3) that these regulations and boundaries should

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[10] A directive is an authoritative statement that is meant to provide instruction on what should be done. In the case of the EU, directives require member states to abide by a particular statement but do not specify how this compliance should be achieved.

[11] At the time of commission multiple embryo transfer and greater doses of stimulating hormones were used. Since the commission was called, the rates of OHSS and multiple pregnancies have decreased substantially (Steward et al. 2014).

be re-evaluated throughout time because of the “increasing pace of knowledge and development” of these technologies (Royal Commission on New Reproductive Technologies 1993:xxvii). The report clearly outlined that reproduction should be regulated. Thus, the Commission was a specific body of biopower where biopolitics were enacted through a creation of a specific report that deemed the government was in charge of determining how life was created. This report shifted who was deemed responsible for regulating reproduction to the government rather than the medical community. Foucault (1978) suggests that a characteristic of modernity is governments increasingly concern with determining matters of life (and death), making the Commissions’ report another example of the intervention of government on matters of life, biopower.

The Commission saw their report as fulfilling the first goal of defining boundaries of ARTs as it provided a “blueprint for how Canadians can deal with new reproductive technologies in the country” (Royal Commission on New Reproductive Technologies 1993:xxviii). While they claimed their report was based on neutral scientific evidence, it was not without controversy as both the Roman Catholic Church and the National Action Committee on the Status of Women (NAC) critiqued the commission (Gerlach et al. 2011). The Roman Catholic Church’s long-standing critique is based on the religious belief that artificial technologies should not be used in procreation as scientists disrupt the natural act of procreation, replacing God as the creator of life (United States Conference of Catholic Bishops 2009). Unlike the Catholic Church, NAC did not want IVF to be banned, but “simply called for a pause, a slowdown, for no new clinics to be opened until we have clearer data on its success and its safety” (Rebick 1990). The NAC saw the Commission’s reported ties to large pharmaceutical industries as preserving the rights of technologies and business interests rather than women. While the NAC criticized the

Commission for failing to take women's reproductive health seriously, other feminist and liberal groups saw the report's proposed ban on such things as surrogacy and the sale of human sperm, embryos and fetal tissue as restricting women's choice and access to family creation ("Proceed with Care Indeed" 1993). Thus, the report's suggestions were both criticized for not fully protecting women and for paternalistically preventing individuals from creating families.

The critique of paternalistic recommendations from Canadian governmental bodies was not unique as Canadian women had historically struggled with rights to abortion and birth control (Gerlach et al. 2011). What was unique, however, was the conversation that arose surrounding risks and benefits of new reproductive technologies in relationship to women's bodies. Unlike discussions surrounding abortion, which focused on women's bodily autonomy, feminist concerns surrounding ARTs emphasized the ways in which doctors and pharmaceutical companies had controlled women's reproduction for their own profits and/or to gain professional authority (Rebick 1990). Feminist scholars have also noted the ways in which women's natural life events such as childbirth (Ehrenreich and English 1973, Martin 1987, Wertz and Wertz 1977), and menstruation and premenstrual syndromes (Bransen 1992, Chrisler et al. 2006, Figert 1996, Riska 2003) became objects of medical intervention through medicalization (Riessman 1983, Riska 2003). These works have focused on the ways in which medicalization restricted women's control over her reproductive body. Feminist critiques showed the importance of women's voices and experiences being considered in the creation of new public policies surrounding new medical technologies and treatments. Similar considerations over women's reproductive rights led the Commission to recommend conservative policies regulating donor eggs. These proposed policies, which limited the eligibility of egg donors to those already undergoing treatment, restricted who could donate based on women's perceived vulnerability to the risks of these new reproductive technologies. Thus, biopolitics arose that situated women as vulnerable to reproductive harm and coercion that these new technologies could bring.

The focus on who should and should not be able to donate and receive an egg created a conversation that focused on the protection of donors rather than who had the right to create a family (Gerlach et al. 2011). The report attempted to ensure that egg donation did not become commercialized in the same way that it was in the United States. That is, the report problematized the ability to pay women for their eggs, deeming the “commercialization of human reproductive material” to be “ethically unacceptable” (Royal Commission on New Reproductive Technologies 1993:593-94). In the report, the Commission deemed sperm and eggs as body parts that could not be sold as they considered it “unethical to allow people to risk their health to sell parts of their bodies” (Royal Commission on New Reproductive Technologies 1993:593-94). This proposal suggested that the legislation should be created to give the Canadian government the power to determine who could exchange their gametes and how they should be exchanged.

With respect to egg donation, the report suggested that the commercialization of gametes should be prevented through the creation of criminal legislation that would ban the “sale of eggs, sperm, zygotes, or fetal tissues, and the advertising for, paying for, or acting as an intermediary for preconception (surrogacy arrangements)” (Royal Commission on New Reproductive Technologies 1993:xxxii). Furthermore, the Commission also considered egg donation to be unethical unless someone who was already undergoing IVF donated her eggs (ibid: 591-592). This proposed prohibition was due to the inherent procedural risks of egg donation (e.g. ovarian hyperstimulation) and the possible risk of coercion. Coercion, or the idea that a prospective donor could be covertly or overtly influenced to donate her eggs, was seen as a risk even in designated (known) voluntary egg donation in which a family member or close friend agreed to donate. Thus, coercion was not only perceived as the monetary incentives offered to potential donors, but also as the sense of "duty" that the Commission believed a family member or close friend might feel towards their sister or friend who was unable to become a mother.

While the Commission proposed to prohibit egg donation unless a current or past fertility patient donated her existing eggs to another fertility patient, the Commission did not suggest that sperm donation should be limited in the same way. The prohibition on egg donation from designated or anonymous donors, who would not already be undergoing the stimulation procedure (i.e. current fertility patients) attempted to protect women from the medical risks and discomforts of donation as well as the coercive potential of asking someone or paying someone for her eggs (Royal Commission on New Reproductive Technologies 1993). In creating this recommendation, the Commission acknowledged that there would be a shortage of donors. They attempted to reduce the number of needed donors by limiting those who could request a donated egg to someone who was medically indicated for egg donation because of disease (e.g., Turner's syndrome) or previous medical treatment (e.g. chemotherapy). This recommendation suggested that women who were post-menopausal should not be eligible to receive a donated egg. Taken together, the Commission's recommendations on who could donate and who was eligible for donation limited the commercialization of gametes and restricted who could create families. These restrictions are not unlike other forms of biopolitics where the government regulates reproduction and sexuality, potentially impinging on who can reproduce and, in this case, who can engage in reproductive treatment.

The Canadian Commission's final report suggested that a Commission on New Reproductive Technologies be created to oversee their regulation. To prevent against complete paternalistic oversite, the report suggested that this newly formed commission should be composed mainly of female members in order to ensure that women's voices would continue to be heard as new information surrounding ARTs surfaced (Royal Commission on New Reproductive Technologies 1993). This commission was tasked with the continuous evaluation of the ever-changing science behind ARTs as well as ensuring that the regulations, once created, were upheld. The newly created Commission was an attempt to assert biopower over new reproductive technologies by clearly defining who was the regulatory body and thus the responsible moral agent.

Although the report clearly suggested that legislation should be passed, it was not until over a decade later that Canada was able to pass the *Assisted Human Reproduction Act* (AHRA). In creating prohibitions surrounding ART use, the *AHRA* served to solidify the Canadian government's biopolitics as it determined who could reproduce and under what conditions.

The Assisted Human Reproduction Act (AHRA)

In keeping with the Royal Commission's recommendations, the *AHRA* protected women and prevented the "trade in reproductive capabilities of women and men and the exploitation of children, women and men for commercial ends" (*Assisted Human Reproduction Act* 2012, s. 2d). It did this by criminalizing paid gamete donation, and by setting-up the Assisted Human Reproduction Council (AHRC). Thus, the AHRC was charged with ensuring that the *AHRA* was followed. It also monitored and assessed the developments of new assisted reproductive technologies. Thus, the AHRC represented an overt form of biopower as it held the responsibility to monitor the use of ARTs as well as new scientific findings that emerged (Baylis and Downie 2013). The AHRC also succeeded in shifting the control of the egg donation process from a purely medical endeavor to one that was the Canadian parliament regulated, the law could enforce, and a multi-disciplinary council oversaw. Thus, the AHRC created multiple moral agents who had various responsibilities to ensure that ARTs were used ethically and legally.

In reflecting the Commission's concerns over the vulnerability of women, the *AHRA* deemed women's health and well-being as something that criminal law should protect; stating, "women are directly and significantly affected by their [ARTs] application and the health and well-being of women must be protected by the application of these technologies" (*Assisted Human Reproduction Act* 2012, 2c). The *AHRA* declared this protection as a *legal* matter that the federal government would regulate rather than medical organizations, suggesting that the profession of medicine was not sufficiently able to regulate its own affairs, requiring the federal government's oversight. The shift of control of egg donation from the medical profession to legal bodies challenged the profession of medicine as reproductive specialists no longer had sole control over the process of egg donation. Instead, laws governed it and a council that was not only comprised of medical professions, but also of bioethicists, lawyers and politicians oversaw its practice. This shift, Foucault (1978) argues, is part of the government's increasing interest in regulating all forms of life.

Challenging the AHRA

The legislation, which restricted medical practice, did not come without challenge as the provincial government of Quebec contested multiple articles (8-19, 40-53, 60, 61 and 68) of the *AHRA*, suggesting that these articles exceeded the federal government's authority. Included in this challenge was the inability to reimburse a donor for donating their sperm or ovum (section 12, see Appendix A). Quebec's challenge came as a way to reinforce the autonomy of the medical profession over egg donation, questioning the federal law's ability to oversee medical and research matters and arguing that Canada's constitution ensured provincial control over all medical matters. Quebec attempted to claim that assisted human reproductive practices were medical matters rather than criminal ones, and thus, giving the province regulatory authority. While some aspects of the act were deemed unconstitutional, the argument failed in 2010 as the Supreme Court of Canada decided that the federal government did reserve power to criminalize the practice of paying for gametes (Annas 2011). Thus, the Supreme Court Decision distinguished between what aspects of assisted reproductive technologies were considered medical, and what practices were considered criminal.,. This decision ultimately upheld the federal government as the moral agent in control over the trade in reproductive goods. In doing so, the Supreme Court provided the government of Canada with the biopower to regulate human reproduction.

Quebec's failure in challenging the *AHRA* was due to the decision that assisted reproductive technologies were not solely medical technologies but rather *practices* that had the ability to "undercut moral values, produce public health evils, and threaten the security of donors, donees, and persons conceived by assisted reproduction" (Attorney General of Canada v. Attorney General of Quebec 2010). Because parts of the act were seen as ensuring the safety of those implicated in the use of reproductive technologies (a federal responsibility) rather than regulating the practice of medicine (a provincial responsibility), Quebec's challenge failed in eliminating the federal government's oversight over all aspects of assisted reproduction (Attorney General of Canada v. Attorney General of Quebec 2010). Annas (2011) describes the Supreme Court's distinction as separating legitimate "good" aspects of ARTs, such as in vitro fertilization and noncommercial gamete donation and surrogacy from the "inherently evil" aspects of reproductive medicine such as cloning, germline genetic engineering, and commercialization of human gametes and pregnancy. The end result was that the provincial government was allowed to regulate the “good” aspects while the federal government, in charge of criminal processes, was given the responsibility of regulating the “evil” aspects of ARTs.

Since the responsibilities of regulation over ARTs was now divided into provincial and federal regulation, the AHRC became limited in its ability to completely oversee assisted reproductive technologies. In addition to being ineffective, the high cost of maintaining the council ($10.5 million/year) also led the government to dismantle the regulatory body (Baylis 2012). Baylis and Downie (2013) have argued that the *AHRC* was “set-up to fail” as the establishment of the AHRC was delayed and the provision of the regulations that would give the AHRC authority never came into existence in part due to the challenge of the Québec government. The disbanding of the AHRC shows the limits that overt forms of biopower, regulatory bodies, have on the practice of medicine. The lack of support was both due to the contentious nature of their work and the unwillingness of the medical professional to support their work. Thus, the failure of the AHRC may show the problem of regulating ethics from outside the practice of medicine[12] as this body had little power over the everyday practices of medicine. With the dissolution of the AHRC, the enforcement of the act became even more difficult, potentially lessening the threat that the *AHRA* had on the medical practice of ARTs and simultaneously diffusing the federal government’s (bio)power.

Limits of the AHRA

While the *AHRA* clearly prohibits the selling of sperm and ovum, this section of the act has never been enforced (Cattapan 2013), despite reports that paid egg donation still occurs

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[12] The United Kingdom’s Human Fertilization and Embryology Authority (HFEA) is an arguably successful model of independent regulation. HFEA was created and supported by the UK government and gained support of the medical profession by having medical professionals on the board. In contrast, the absence of obstetricians and gynecologists on the board of the AHRC and the opposition to the council from the beginning meant that the AHRC lacked sufficient power to oversee ARTs in Canada (Nelson 2013).

(Motluck 2010). In 2010, a journalist reported that some clinics were still offering their clients access to paid egg donation, claiming that the act's prohibitions did not apply to them as they were "grandfathered in" (Motluck 2010). Motluck's (2010) findings showed the limits of the Canadian legislation as the lack of a regulatory body meant that the clinics could interpret the law in a way that fit their needs. Sociologist Kathleen Hammond (2015) has also documented how intended parents often pay egg donors, observing the online marketplace that has arisen for egg donors. These findings suggest that since there is no biopolitical force to ensure Canada's compliance with the *AHRA*, paid egg donation still occurs within Canada (see also Chapter 4 and 5).

The existence of illegal contracts between egg donors and recipients is also due to the lack of clarity over what is and what is not considered a reimbursable (legitimate) expense. Section 12 of the *AHRA* allows for reimbursable without defining them. Currently, the *AHRA* (2012) states,

> 12(1) no person shall, except in accordance with regulations, (a) reimburse a donor for an expenditure incurred in the course of donating sperm or an ovum…. (2) no person shall reimburse an expenditure referred to in subsection (1) unless a receipt is provided for that expenditure.

This lack of definition is especially problematic in that those found violating this section (i.e., paying a donor for an expense that is not considered receiptable) could be subject to a $500,000 fine and imprisoned for up to 10 years (*Assisted Human Reproduction Act* 2012). The Canadian Fertility and Andrology Society has critiqued section 12 of the Act as "vague and ambiguous," claiming that this section creates "anxiety for our members" (Roberts 2016) who must counsel their clients on what they consider receiptable. The anxiety that the act creates, however, shows the act may still be an effective form of biopower as physicians are concerned about how the law may interpret their actions. This concern shows the ways that biopower can covertly operate as physicians delegate contentious tasks to others to avoid potential prosecution (see chapter 4)

Both the lack of clarity of the regulations and the lack of enforcement of the *AHRA* has brought criticism from bioethicists (Baylis 2012, Baylis and Downie 2013, Cattapan 2013, Downie and Baylis 2013), lawyers (Campbell 2002, Young and Wasunna 1998), journalists (Black 2015, Motluck 2010), sociologists (Hammond 2015), and patients, who all argue for the extra-medical regulation of donation. While these actors agree that the government should regulate the practice of egg donation, they disagree on what these regulations should be. Arguments not only criticize the lack of enforcement and prosecution of the law, but some call for a change to the prohibition of compensation (e.g. Cattapan and Cohen 2013). For example, some (see Baylis 2012) argue for stricter enforcement of the AHRA, agreeing that the paid practice of egg donation should (continue to) be prohibited. Others argue for a clarification of law so that standards are created surrounding receiptable expenses. Both arguments, however, require the government to exert more overt forms of biopower so that citizens and fertility clinics are aware of what actions are considered legal.

The future of the AHRA

Health Canada has recently recognized these arguments and has released a draft in order to (potentially) clarify the current *AHRA* guidelines surrounding compensation (Philpott 2016). This new document, *Towards a Strengthened Assisted Human Reproduction Act*, continues to emphasize the concern over the “risks to human health and safety arising from the use of donor sperm and ova for the purpose of assisted human reproduction technologies” (Health Canada 2017:7). Although the document recognizes new medical safety measures to protect donor-conceived children (e.g., implementing more stringent genetic screening protocols for donors), the document does not recognize the change in protocols for donor stimulation, which arguably makes the donation process safer for the donors (Vidal et al. 2013). The report also fails to acknowledge the increasing numbers of Canadians who either travel overseas for egg donation (Hughes and DeJean 2010) or import frozen eggs from U.S. egg banks. Instead the document continues to focus on prohibiting the "trade in the reproductive capabilities of women and men, and the exploitation of children, women and men for commercial ends" (Health Canada 2017:5), attempting to clarify the section 12 of the act that allows for compensation. The proposed expenditures that may be reimbursed to donors are defined as:

> travel expenditures, including expenditures for transportation, parking, meals and accommodation, expenditures for care of dependents, expenditures for counselling services, expenditures for legal services and disbursements, expenditures related to shipping (for sperm and ova only), expenditures for other items or services that are provided or recommended in writing by a qualified medical practitioner, [and] for ova donors and surrogates expenditures for medication (Health Canada 2017:24)

Egg and sperm donors claiming these expenditures must provide a receipt and must not gain monetarily from the expenditure. While the report outlines the government's position on acceptable expenditures, it has not been transposed into law, meaning that expenses related to egg donation remain ambiguous.

While Health Canada debates the new modifications to the act that would more clearly define reimbursable expenditures, a Liberal Member of Parliament, Anthony Housefather has introduced a private-member's bill (C-404) that would eliminate the *AHRA*, leaving provincial governments responsible for regulating gamete donation (Housefather 2018). The bill was tabled on May 29, 2018 meaning that parliament will consider the bill, which seeks to decriminalize payment for gamete donation and surrogacy (Connolly 2018). This bill has been controversial as some claim that the bill will only serve to further commodify women's bodies and increase the price of ARTs while others see the proposed amendment as a sign of progress allowing intended parents access to donors (Clarke 2018, Housefather and Cohen 2018). This twenty-eight-year long biopolitical debate over the practice of egg donation illuminates the ethical and legal challenges of what was once considered solely a medical endeavor. It also shows the limits and breadth of biopower as Canada grapples with what it means to have a law that has never been enforced but still places restrictions on donation.

Consequences of the AHRA

Ultimately, the Canadian *Assisted Human Reproduction Act* and its proposed amendments attempt to decommercialize the process of gamete donation. This decommercialization is based on the desire to prevent the commodification of human life as well as prioritize "women's health and well-being" (Royal Commission on New Reproductive Technologies 1993). Cattapan (2013) argues that while the protection of women's health is a positive goal, Canada has failed to seriously consider how these laws have affected women's reproductive health choices and has instead used the language of protectionism to justify current public policy and law. The *AHRA* does attempt to protect vulnerable women by demanding altruistic donation. However, Cattapan (2013:206) argues that the *AHRA* fails in protecting vulnerable women in that the law "has done little more than create a legal situation that too often pushes paid gamete donors and surrogates abroad and underground." Furthermore, the mandate on altruistic donations has created shortages in the number of eggs, as some women do not want to undergo the procedure without some compensation (Hammond 2015). Since Canadian women may have difficulty finding an altruistic egg donor, they may purchase and ship eggs from abroad or travel abroad themselves in order to gain access to treatment—in 2008, 80% (n=363/452) of reproductive travel was for egg donation[13] (Hughes and DeJean 2010).

The mandate for altruistic donation has restricted the practice of egg donation in Canada, limiting the ability of Canadian fertility professionals to practice reproductive medicine using donor gametes (see chapter 4). This state of affairs has created a debate between fertility professionals, bioethicists, fertility patients and potential donors with some arguing for the clarification of reimbursements (Baylis 2018a) and others calling for the decriminalization of donation through an amendment to the *AHRA*, which would ultimately provide patients access to compensated donors within Canada (Housefather and Cohen 2018).

While the debate surrounding the *AHRA* continues, there is a lack of documented information about how the current *AHRA*'s prohibition on paid gamete donation affects Canadian fertility care physicians' ability to practice egg donation. What is known is that the primary reason fertility patients in Canada travel abroad for care is to find an egg donor (Hughes and DeJean 2010). The travel for egg donation suggests that although the *AHRA* is not enforced, it still impacts fertility care professionals' practice of medicine as fertility professionals are reluctant to break an established law (see chapter 4). Thus, the *AHRA* still remains an effective form of biopower as the threat of prosecution remains for intended parents and clinics (Foucault 1991).

Even without an explicit body to regulate the practice of gamete donation within Canada, the mere threat of prosecution exerts a form of covert biopower, effectively limiting the practice of gamete donation through regulation without enforcement. As a result, the *AHRA* potentially

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[13] Since there is no regulatory body, Canada also lacks a system to track who is receiving egg donation treatment in Canada or elsewhere. Thus, this 2010 study is the most recent data.

threatens the status of fertility care professionals by placing legal restrictions on the type of egg donation practices that these professionals can provide. It does this by limiting the type of eggs that a fertility professional can offer his/her patients, and by creating a system in which physicians must rely on other non-medical professionals to supply these eggs (see chapter 4). This limitation means that fertility medical professionals are unable to oversee the entire process of egg donation and patients must navigate different pathways of online egg banks, Canadian agencies and abroad clinics in order to determine which possibility is best for them (see figure 1). Ultimately, the system means that patients will receive different types of care depending on their location, network of family members and friends, financial resources, and willingness to travel (see Table 1).

The ability to travel to other places, however, is dependent on global biopolitics where other countries bioethical complexes create markets of care. Legislative frameworks often determine these markets of care, which restricts certain practices and allows for others. In the next section, I examine the European Union's Directive surrounding donated gametes. I then go on to show how the Czech Republic and Spain created legislation that allowed them to emerge as global players in the marketplace of egg donation.

EUROPEAN UNION LAWS AND REGULATIONS

Canada is not the only country concerned with the ability for ARTs to commercialize human reproduction and human body parts. In 2004, the European Union, representing 25 countries, created a directive in order to set "standards of quality and safety for the donation, procurement, testing, processing, preservation, storage, and distribution of human tissues and cells" (European Parliament and Council Directive 2004). The creation of these standards was based on part three of the European Community treaty which established rules across the

Member States involving public health (see *Treaty Establishing the European Community* 2002). These standards could be argued to be an expansion of biopolitics as a political and economic body comprised of multiple Member States determined that reproduction was a "vital" characteristic of human life that should be regulated (Rabinow and Rose 2006).

The EU Directive on Human Tissues and Cells (2004/23/EC) set out to equally protect human health through the development of quality and safety standards. With respect to donation of cells, the directive stated that "1. Member States shall endeavor to ensure voluntary and unpaid donations of tissues and cells. Donors may receive compensation, which is strictly limited to making good the expenses and inconveniences related to donation" (2004/23/EC)[14]. Through this directive, the EU attempted to ensure "voluntary and unpaid donations" and prohibit the commercialization of human reproduction. The directive, however, did not specify what was the "expenses and inconveniences related to the donation" were allowing for individual Member States to regulate the procurement of gametes with their own country-specific laws. The vagueness of the directive surrounding compensation of donors allows for Member States, through the transposing of the directive into law, to determine laws that reflect the cultural and societal values of their own country (Pennings 2004). Countries separately determine, through their own laws, what "voluntary and unpaid" donation means and how much compensation donors are allowed to receive (2004/23/EC). This directive, thus, created a flexible form of

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[14] While the 2004 directive stated that cells should not be commercialized, it did not specifically address reproductive cells. Thus, in 2006 before the 2004 directive came into force, the Commission specified how reproductive cells should be tested and procured to be in compliance with Directive 2004/23/EC. A revised directive (2006/17/EC) explicitly laid out requirements for testing of donors while necessitating their "health, safety and privacy" (European Parliament and Council 2006: 2(8)). It kept in place the requirement that donation of human reproductive cells be unpaid and voluntarily given.

biopower which allowed for the local biopolitics of each country to determine their own specific legislation.

These various interpretations of what is considered compensation have created different rules surrounding compensation of donors with some only allowing compensation for proven expenses (i.e., France), others creating an allowable compensatory amount (i.e., ~€900 in Spain), and some banning egg donation altogether (i.e., Germany) (Pennings, Klitzman and Zegers-Hochschild 2016). Thus, the lack of a specific directive creates a patchwork of regulations in which Member States have the ability to control how reproductive technologies are used as long as they meet the EU directive's minimum standard. It could be said that the EU Directive establishes the biopolitics within which the Member States must align their own laws.

One way in which the EU exerts its biopower is through an interdisciplinary organization, the European Society for Human Reproduction (ESHRE), which gathers information and monitors ART use across the Member States. A 2009 ESHRE report found that while 15 of the 27 (56%) Member States allow for embryo donation, financial compensation for donors is only allowed in 12 of 27 (44%) of the states. Additionally, non-anonymous egg donation is forbidden in 11 of 27 (41%) Member States and allowed in 9 of 27 (33.3%) Member States. The various laws in these countries show how a similar biopolitical framework, the EU Directive, can result in various bioethical complexes, represented by country-specific regulation and regulatory bodies.

Cross Border Reproductive Care

Since the EU directive allowed for various EU countries have disparate policies surrounding assisted reproductive technologies and EU citizens are allowed to freely move across EU borders, EU citizens often travel across borders for reproductive care (i.e., cross-border reproductive care (CBRC)). While it is unknown how many EU citizens travel across borders specifically for egg donation, approximately 14,000 patients per year travel for some sort of reproductive care (Pennings 2004). Reproductive travelers often travel to the Czech Republic and Spain for egg donation as both countries have strong donor programs, partially due to their ability to compensate donors (~€900 in Spain and ~€600 in the Czech Republic) (Pennings et al. 2014).

Part of my choice to study the Czech Republic and Spain as sites where Canadian's travel to for their reproductive care stems from their more permissive bioethical complexes. Their polices allow for compensated anonymous gamete donation (ESHRE 2009). The ESHRE report recognizes that the regulation in these countries make them "natural recipients" for egg donation as they both allow for anonymous donation and provide compensation for donors. In other words, since their bioethical complexes allow for the practice of compensated egg donation, the CZ and Spain have become locations where intended parents, including Canadian intended parents, can find donors quickly, easily and cheaply.

Czech Law

The *Act on Research on Human Embryonic Stem Cells and Related Activities 227/2006* regulates medically assisted reproductive services in the Czech Republic. This law restricts single women and lesbian women's access to reproductive technologies, necessitating that both persons within a couple provide written consent before treatment. In order to donate eggs, one must be between the ages of 18 to 35. Once eggs are donated, the donor gives-up any parental rights as it is the recipient rather than the donor who maintains parental rights (Busardò et al. 2014). As outlined both in the Czech law and the European Tissue and Cell Directive, every donor is required to undergo testing for sexually transmitted infections (i.e., HIV, HPV, Hepatitis

C, Syphilis), and genetic diseases (i.e., karyotype 46XY, spinal muscular atrophy, cystic fibrosis). The law also requires donors in the Czech Republic to remain anonymous, implicating the medical professionals in ensuring their anonymity. In the implication of medical professionals, the law's overt biopower creates a responsible moral agent, signaling who is responsible if anonymity is not preserved.

With regards to compensation of donors the law states,

> The donor shall be entitled to compensation of expenses effectively spent in relation to the collection. These expenses shall be reimbursed to the donor by the operator of the health care institution where the collection was performed upon his/her request. The operator of the health care institution may ask the female recipient undergoing the artificial insemination or operator of the health care institution, to which the gametes or embryos were supplied, to reimburse these expenses (*Czech Republic Act on Research on Human Embryonic Stem Cells and Related Activities [Translated]* 2006, Section 8).

While this law does not specifically discuss what expenses are considered "spent in relation to collection," fertility clinics in the Czech Republic routinely compensate donors after they donate their eggs. The amount compensated often varies, but generally is around 15,000 CZK (580€=$890 CAD) (Pennings et al. 2014). Here, the fertility clinic is assigned responsibility for compensation.

According to the Czech law, the amount that a clinic can compensate a donor should reflect the amount the donor has spent donating the eggs. However, in my research I found that Czech clinics did not required their egg donors to provide receipts of their expenses but instead often reported that they gave women a set amount of money (~18,000 CZK=700€=$1090 CAD) for their donation, regardless of the amount of money she spent donating the eggs.

Since the laws do not specify the compensatory amount and allow for the clinics to determine this amount, the law could be said to exert a weaker form of biopower. However, as the clinics are legally responsible for this compensation, they are incorporated into the bioethical complex thereby becoming responsible for enacting part of the law. The clinics, through their responsibility to compensate donors an “appropriate amount” and keep them anonymous from the intended parents, enact the laws. A failure to comply would result in breaking the law and a loss of license of the clinic, providing an overt threat to clinics who do not comply.

Spanish Law

Two laws in Spain regulate medically assisted human reproductive technology services, *The Law on Medically Assisted Human Reproduction Techniques 14/2006* [*Ley 14/2006, De May 26, Sobre Técnicas De Reproducción Humana Asistida*] and the *Biomedicine Law 14/2007*. These laws also comply with the European Union Tissue and Cell Directive, requiring testing of the donors for sexually transmitted infections and genetic diseases as well as that the donation is used for reproductive or research purposes. Section five of the 2006 act prohibits the commercialization of reproductive materials, ensuring that the donation is nonremunerative (*Ley 14/2006, De May 26, Sobre Técnicas De Reproducción Humana Asistida* 2006). The authorized reproductive center (i.e., the fertility clinic) is charged with ensuring that the donor is encouraged to donate altruistically, without the incentive of economic benefits. The fertility clinic manages the contract, providing a responsible moral agent. Additionally, unlike in Canada where Health Canada has minimal oversight of the reproductive clinics, in Spain the Minister of Health exerts overt biopower through monitoring the reproductive clinics in order to ensure that that donations are both safe and non-commercialized (Busardò et al. 2014). While the Spanish law is concerned with the non-commercialization of egg donation, the law does not outline a specific amount that a donor can be compensated. Instead, the donor is allowed to be compensated for such things as physical discomforts, travel and work expenses. In a 2014 survey done of fertility clinics across

Europe, Pennings et al. found that the amount a donor was given ranged from 700 to 1300€ ($1072-1990 CAD).

DETERMINING THE MORAL AGENT

It is notable that both the Czech Republic and Spain outline the contract that the reproductive clinic has with the donor, placing the responsibility of compensation and safety of the donor directly on the clinic, rather than failing to mention who the moral agents are with regards to ARTs (i.e., the Canadian law). Although neither the Czech law nor the Spanish law clearly defines what expenses that a donor can be compensated for, the laws make the clinic the moral agent who is responsible for compensating the donor for these expenses. Specified health bodies, which are directly tasked to ensure the non-commodification of donor gametes, oversee the Spanish and Czech clinics.

The biopolitics in each country also affect how egg donation is practiced in each country. In the Czech Republic and in Spain, the clinic is legally obligated to ensure that the donor provides informed consent and is given an appropriate amount of compensation. This responsibility means that fertility clinics recruit donors in the Czech Republic and in Spain. While fertility clinics in these countries may rely on another fertility clinic to supply eggs in a time of shortage or unavailability of a specific type of donor, it is (medical) fertility clinics that recruit, screen and counsel donors rather than (non-medical) agencies or fertility patients themselves (see Figure 1).

In morally implicating the Czech and Spanish fertility practitioners, a more overt form of biopower is exerted as the fertility clinics are regulated and deemed responsible for violations in the law. These systems are in contrast to the Canadian legislation where it is unclear who the law would prosecute. Thus, a move covert form of biopower is exerted—Canadian physicians abide by the law because of the potential for prosecution.

FINDING AN EGG

In deeming individuals, rather than clinics, as responsible moral agents, and by not explicitly defining what constitutes a reimbursable expense, Canadian fertility practitioners have increasingly relied on Canadian intended parents to find their own egg (see chapter 4). Figure 1 describes the process by which Canadian intended parents navigate the global bioethical complex to find an egg. This navigation is global rather than national because of the ease at which patients and gametes can travel across borders and because of the markets that already exist for intended parents in search of eggs. Martin (2015) has argued that these pathways are part of an enactment of global biological citizenship whereby individuals chose the laws that best suit their reproductive needs.

The laws present in the Czech Republic and Spain allow for fertility travelers who may be denied fertility care in their home country to seek out care abroad. In these two countries, fertility clinics continue to maintain jurisdictional control over the egg donation process and are able to compensate donors. This control over the process of egg donation consists of everything from matching donors with recipients, recruiting, consenting, and compensating the donor, and billing the patient for the entire treatment process (i.e., donor fee, retrieval costs, and transfer costs) (see Figure 1). Furthermore, recipients are not allowed to bring-in their own donor as this act would violate the countries' laws that require anonymous donors. Thus, patients who need an egg donor and visit a Spanish or Czech clinic can expect to go through a predetermined process with clear steps and costs. This continuity helps attract foreign patients to their clinics, as patients traveling from far away destinations such as Canada can be reassured that embryos will be implanted into their uteri once they arrive at the clinic. In some cases, patients can also opt-in to “live birth guaranteed programs” where clinics, for a set amount, will guarantee a live-birth in a specified number of transfers.

The organizational structure of the Czech and Spanish clinics that comes with their ability to compensate their donors a set price, exists within a system of a more overt form of biopower where it is clear who is the moral agent responsible for abiding by the laws. This overt biopower is in contrast to the Canadian system where the law is unclear of what constitutes a receiptable expense and who is responsible for ensuring that the law is followed; a covert form of biopower. These two different systems of biopower represent two different ways governments have attempted to regulate reproduction through country-level biopolitics. The limitations of national governments’ biopower are illuminated by the increasing ease with which individual subjects navigate “global webs of science and capitalism” (Gerlach et al. 2011:10) through cross border reproductive care and the importation of frozen eggs. However, this active movement to find an egg donor may only represent the individualization of responsibility, where Canadian citizens become responsible for the type of donation they pursue. The global movement of patients across borders for fertility care exemplifies the ways in which state bodies and individual subjects co-constitute each other and allows for an examination of the ways in which the individual’s ability to enact self-control is embedded in systems of biopolitical rule (i.e., *AHRA*, EU Tissue and Cell Directive, *Spanish Law* 14/2007, *Czech Law* 227/2006) and biomedical market expansion.

DISCUSSION

This chapter examines the various types of bioethical complexes that exist by outlining the various forms of biopolitics that exist in Canada, the European Union, the Czech Republic, and in Spain. In doing so, I highlight the variance in biopower that exists in response to the desire to curtail the commercialization of reproduction. The purpose of this study is not to compare the experiences of intended parents in each context, but rather to explore how Canadian intended parents find an egg donor under the Canadian biopolitical system of egg donation.

This chapter serves as an outline of the different biopolitical systems that Canadian intended parents may enter into when searching for an egg. I have shown how different biopolitical systems create “sending” countries (i.e., Canada) and different “receiving countries” (i.e., Czech Republic and Spain) that ultimately become connected through cross border reproductive care. In the chapters that follow, I highlight the various pathways that Canadian intended parents use to find an egg donor and how these pathways are determined based not only on the biopolitics created by the *AHRA*, but also the global marketplace for egg donation. In other words, this research explores how intended parents navigate the global bioethical complex of egg donation characterized by various national and international regulations, and markets to find an egg.

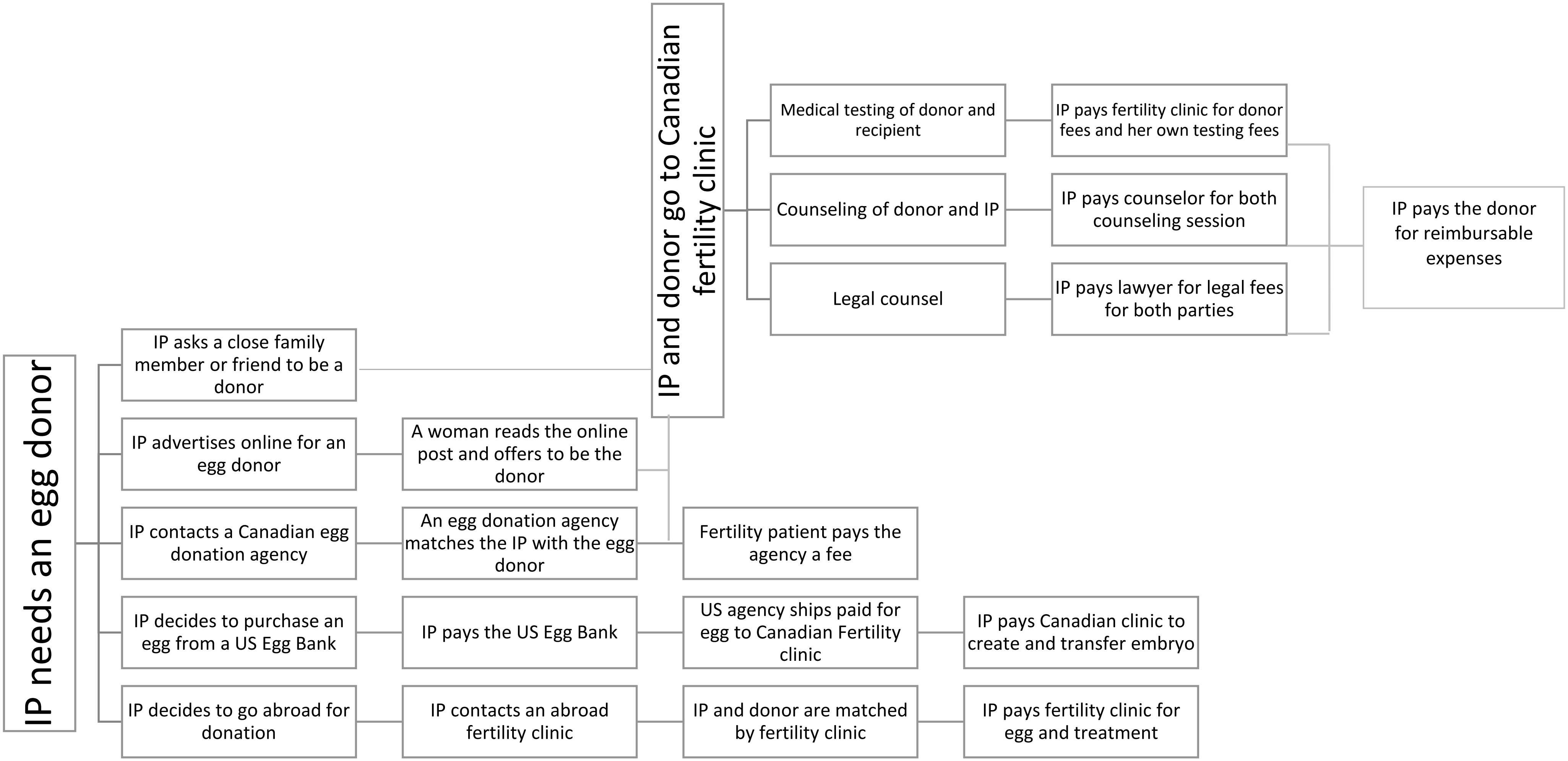
In Chapter 4, I detail how the Canadian medical profession responded to the system in which it is illegal to purchase an egg. I show how these physicians engage in boundary-work. In chapter 6, I then contrast this “boundary-work” (Gieryn 1983) to the Czech and Spanish system whereby they use their cultural health capital to attract foreign patients (Shim 2010). Throughout the dissertation, I show how Canadian intended parents’ experiences differ in each biopolitical marketplace as they must engage in various types of entrepreneurial activities (i.e., asking family members or friends, paying an egg donor or engaging in cross border reproductive travel) and are cared for by professionals in different regulatory contexts. Although their experiences may differ, I argue that the process of finding an egg is still a biopolitical activity where intended parents enter into the global marketplace of egg donation. In this marketplace, inequalities are reproduced as money is always exchanged albeit to different moral agents. Ultimately, this research provides empirical evidence of the commercial process of egg donation both within and outside of Canada, regardless of the intention of the *AHRA* to decommercialize reproduction.

Table 1 Canadian IVF clinics and type of egg donation offered

Clinic	Type of Donation Offered				
	Known Donor	Canadian Agency	US Egg Bank	Referral Abroad	Referral to Canadian Clinic
Clinic 01	●		●		
Clinic 02	●	●			
Clinic 03	●		●	●	
Clinic 04	●		●	●	
Clinic 05	●	●	●		
Clinic 06	●		●	●	
Clinic 07	●	●	●		
Clinic 08					●
Clinic 09	●		●		
Clinic 10	●	●			
Clinic 11	●		●	●	
Clinic 12	●		●	●	
Clinic 13	●	●	●	●	
Clinic 14	●		●		
Clinic 15	●		●	●	
Clinic 16	●		●		
Clinic 17	●			●	
Clinic 18	●			●	

N.B. The table above describes the types of donation services the clinics in my sample offered. While I did not interview all clinics in Canada, the clinics not represented in my sample do not have other ways of having their patients find egg donors as per the information gathered from their respective websites.

Figure 1 Pathways of finding an egg in Canada



Nb. IP= Intended parent

Chapter 3
Methodology: Feminist empirical bioethics in reproduction

EPISTEMOLOGICAL BACKGROUND

Although reproduction is often seen as strictly a biological event, sociologists of reproduction have argued that reproduction is a social process whereby laws, social arrangements, cultural practices, science, and medicine come together to affect individuals' embodied experiences of reproduction (e.g., Ehrenreich and English 1973, Ginsburg and Rapp 1995, Martin 1987). Sociologists and anthropologists of reproduction use existing empirical methods, including ethnography, interviews, and surveys, to illuminate social and ethical issues, such as the use conception and prenatal technologies, and pregnancy surveillance (e.g., Almeling 2007, Armstrong 1998, Rapp 1999). Scholars of reproduction often take a situational approach (Clarke 2005, Haraway 2008), placing women's voices at the center of their research in an attempt to more fully understand the embodied experience of reproduction and how individuals navigate ethical and moral concerns that arise from new reproductive technologies (Franklin 1997, Pande 2010, Thompson 2005). By placing women's voices at the center of reproduction, researchers and policymakers can use these lived experiences to think about how reproduction is and should be regulated.

Feminist scholars have argued that women's experiences are especially important in thinking about regulation because of the historical ways that women's bodies have been controlled through reproduction (Rapp 2001, Reineke 2008). Thus, to better understand how the prohibition on the criminalization of egg donation affects women's reproductive lives, I have chosen to examine women's experiences with this legislation. I combine these experiences with professionals' perspectives to more fully illuminate how this legislation affects the practice of egg donation, and thereby, the receipt of care. This dissertation uses a feminist empirical bioethics framework (Kenney and McGowan 2014, McGowan, Fishman and Lambrix 2010, Rapp 1999) to understand how sociocultural factors such as laws and individual understandings of morality and ethics impact the medical practice and the receipt of egg donation.

My work is rooted in a feminist empirical approach to bioethics because of the way that these methods allow for the combination of critical empirical work with an understanding of moral frameworks. A feminist empirical perspective allows for the acknowledgement that "all knowledge attempts are socially situated" (Harding 2008:334) without (always) falling into cultural relativism. That is, a feminist perspective allows for the embodied experience of individuals to vary across time and place while still allowing for science to uncover those experiences. Unlike a traditional approach to bioethics, which presupposes rationalism and individualism, feminist bioethics questions the nature of knowledge in medicine and in ethics, offering a way to understand how power and social positioning may affect interactions and decision making in medicine and research (Fitzpatrick and Scully 2010). By interviewing both professionals' and recipients, I was able to see how the law shaped relationships of power between professionals and recipients. In examining these relationships, I also illuminated how these relationships affect individuals' conceptualization of reproductive ethics. Comparing these perspectives also allowed me to see how individuals used various forms of social and economic capital to navigate their decision-making and how individuals also used this power to shift ethical responsibility.

Another goal of a feminist approach to bioethics is to approach a research topic with an understanding that science (including social science) is a social enterprise; a *practice* of knowledge dependent on individual's belief systems that drive research questions and choices of methods[15] (Longino 1990). Objectivity, thus, is a matter of degree that various perspectives can challenge and transform to create an understanding of a phenomenon the scientific community accepts (Longino 1990). Thus, a feminist approach to bioethics understands how the research question can shape the methods that the researcher employs and the knowledge that is gained. For example, a premise of this dissertation is that the effects on the prohibition on paid egg donation is a question worth answering and those who are affected by the donation in their professional and private lives have important knowledge surrounding this topic.

I have chosen to use established social science research methods to answer my questions despite criticism that these methods may reinforce existing power structures, allowing some individuals to do research for "others" (Smith 1987). Like Longino (1990), I argue that the use of standard empirical methods allows for the evaluation of results and the ability for researchers to build upon one another in a democratic scientific community that not only tolerates criticism but uses that to inform future research practices. I have specifically chosen to use in-depth interviews as they may also help to overcome the problem of "speaking for others" as they allow for participants to speak for themselves, even though their words are analyzed and interpreted.

IN-DEPTH INTERVIEW METHODOLOGY AND DATA

Semi-structured in-depth interviews have become a standard way to better understand how individuals make complex ethical decisions (Weiss 1995). They allow for participants to explain their experiences in their own words and the researcher to ask follow-up and clarifying questions that are particular to their experiences. They are also helpful in understanding an individual's decision-making process as interviews allow for a deep exploration into a subject

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[15] In Appendix E, I discuss how my own positionality affected my research design, questions, data collection and analysis.

matter. Scholars of reproduction have particularly noted their usefulness in better understanding how individuals make moral decisions (McGowan, Fishman and Lambrix 2010, Rapp 1999). Although results are not generalizable to the larger population of study, in-depth interviews can illuminate key concepts and processes that allow for a better understanding of the ways that cultural norms and institutional practices shape individuals' moral decision-making (McGowan, Fishman and Lambrix 2010).

Since I designed this research to illuminate the ways that individuals negotiated their own moral values within broader legal principles and how these principles factored into their decisions to undergo egg donation or provide care for fertility patients, I have chosen to use in-depth semi-structured interviews to better understand the processes by which individuals negotiated these values and made reproductive decisions. In talking with both professionals and recipients of egg donation, I was also able to capture a variety of perspectives, allowing for these viewpoints to be compared and contrasted. The main source of data come from 98 in-depth interviews that I performed with recipients of egg donation and fertility professionals (see Table 2). I customized the interview guides for each type of interviewee (see Appendix B). Although I had separate interview guides for Canadian and abroad medical professionals, other fertility professionals, and egg donor recipients, each interview touched upon the interviewee's own views regarding compensation of egg-donors and the laws that governed the practices. I recorded all but three interviews and transcribed them verbatim. The three interviews were not recorded as one respondent did not consent to be recorded and the other two recordings failed. The data from these three interviews are based on my notes taken during the interviews and elaborated from memory. The McGill Research Ethics Board (REB #431-0416) approved this study. All data reported use pseudonyms. I collected data from May 2015-March 2018.

To ensure reliability of data, scholars often use multiple methods and sources of data to triangulate their data (Denzin 2017[1978], Flick 1992). By using multiple sources of information, the researcher is better able to understand the viewpoints of the social and institutional actors, participating in her study. To triangulate my data, I collected data from professionals who provided recipients with care and also the recipients themselves. In addition, for the abroad fertility clinics, I performed a qualitative content analysis of the websites and brochures to better understand their strategies for targeting international participants.

Fertility professionals

I choose to interview a variety of fertility professionals including physicians, nurses, egg donor coordinators, counselors and lawyers because of the way that the *AHRA* changed the practice of fertility medicine from a solely medical endeavor to one that increasingly relied upon the input of other professionals (see chapter 2). I interviewed both health care practitioners in Canada and professionals in the Czech Republic and Spain so that I could better capture the perspectives of individuals that may interact and care for Canadian patients in need of egg donation. By interviewing practitioners in different legal jurisdictions, I was also able to see how different legislations allowed for different practices and how this legislation influenced professionals' perspectives on the morality of paid and unpaid egg donation. In all, I interviewed 74 fertility care practitioners (see Table 2).

My choice of the Czech Republic and Spain for sites to recruit professionals was because of the popularity of these two sites for Canadians and other fertility travelers (Shenfield et al. 2010), the survey Hughes and DeJean (2010) that identified the Czech Republic and Spain as a destination country for Canadians,[16] the discussions by Canadians on fertility forums of traveling to both destinations, the presence of similar legislation regarding the compensation of donors (see chapter 2), and the relatively low cost of travel to these countries. For example, Shenfield et al. (2010) show that in their survey of European countries, Spain (62%) and the Czech Republic (52%)[17] were more likely to provide egg donation and embryo donation to fertility travelers as compared to other European destinations. Although Hughes and DeJean (2010) identified the United States and Mexico as other destination countries for Canadians, I choose not to interview professionals in these two locations. I excluded the United States because of the changing practice of egg donation, which meant increasingly eggs were being shipped to Canada rather than Canadians traveling to US sites. In addition, I wanted to study clinics that specifically targeted international patients. While the US does treat international clients, the clinics are largely not developed for the purpose of treating international clients as they are in the Czech Republic and Spain. I excluded Mexico because of the relatively few fertility clinic locations and the presence of the Zika virus, which posed a risk to developing embryos. This risk suggested that there may be fewer fertility travelers going to Mexico for egg donation, especially considering Health Canada's warning to expectant mothers.

In this dissertation, I refer to those involved in the medical aspect of the donation who worked at a fertility clinic as medical practitioners/professionals[18]. To identify Canadian medical

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[16] The survey by Hughes and deJean (2010) does not report individual treatment cycles or percentages but notes that "other" destinations for fertility travel include the Czech Republic and Spain.

[17] The actual numbers of egg donation cycles were not provided by the study.

[18] Although two counselors in my sample were employed by a fertility clinic for at least part of their work-week, I do not call these individual "medical practitioners" as most of the counselors in my sample had a private practice and dealt with the psychosocial aspects of donation. Therefore, their experiences more closely represented other fertility professionals in that they negotiated the patients' attitudes towards egg donation rather than their medical treatment.

practitioners, I contacted every clinic (n=36) in Canada via email and asked if a physician, nurse, clinic manager, or egg donor coordinator would be willing to share their experience caring for Canadian patients in need of egg donation. Eighteen clinics agreed to participate; only one clinic refused participation based on time constraints, while 17 clinics did not respond. The 18 participant clinics make up 50% of the Canadian fertility clinics and consist of the perspectives of 19 medical practitioners—two egg donor coordinators, two nurses, and 15 physicians. While all clinics from across the country were contacted for an interview, most of the clinic representatives interviewed were located in the three major cities of Canada—Montréal, the Greater Toronto Area, and Vancouver. Although I was able to interview a large proportion of representatives from Canadian clinics, my sample is not representative of all Canadian clinics or their members. I attempted to conduct the interviews in-person at the fertility clinic (n=13) to have a better understanding of the atmosphere of the clinic. For these interviews, I took field notes based on tours of the clinic on the appearance of the clinic. This allowed me to better understand how these fertility clinics compared to those located in the Czech Republic and Spain. The other six interviews took place over the phone.

To identify clinics located in the Czech Republic and Spain, I performed a Google search of fertility clinics located in both the Czech Republic and Spain. I then scanned their websites, ensuring that the clinic offered egg donation to foreign patients. I identified 17 clinics in the Czech Republic and 21 clinics in Spain. I used patient portals, emails and/or phone-calls to contact all identified clinics. I choose to initiate contact and perform all interviews in English because this method of contact would also allow me to (partially) see how potential fertility travelers from Canada would communicate with the clinics. Eight (47%) clinics in the Czech Republic and 10 (45%) of the clinics in Spain allowed for me to speak with at least one of their fertility clinic staff (see Table 2). The remaining clinics either did not respond to follow-up emails or phone calls (n=22, 58%) or refused to participate (n=1, 3%). Four clinics in the Czech Republic allowed me to speak with multiple members of their fertility team (see Table 2). I traveled to the Czech Republic and Spain once in June of 2015 and then again in April of 2016 to conduct the 23 interviews with fertility clinic staff. I spoke with eight physicians, two embryologists, seven patient coordinators, one nurse, two clinic managers, and three marketing specialists. All but one interview was conducted in-person.[19] For every in-person interview, I took field notes surrounding the location and the design of the clinic to allow me to compare how these clinics compared to those clinics in Canada. I also performed a qualitative content analysis of the brochures and websites (n=36) that each fertility clinic provided me. These websites allowed me to better understand how each clinic positioned themselves in the global market of fertility services.

To gain the perspective of other fertility professionals, I contacted all advertised Canadian fertility lawyers (n=26) and fertility counselors (n=59) via publicly accessible email/phone number or I approached them in person at the 2016 Canadian Fertility and Andrology Society (CFAS) meetings in Toronto. Eleven (42%) of the fertility lawyers agreed to participate and 18 (31%) of the counselors agreed to participate. Because of the dispersal of these practices across Canada, I conducted most of the interviews over the phone; eight of the interviews were performed in-person at the CFAS meetings.

I identified five egg agencies, including one frozen egg bank, and seven frozen egg banks in the United States that advertised partnerships with Canadian clinics. I contacted every egg

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[19] The one interview was conducted over the phone because the participant was on medical-leave and did not return to her job until after I had left the country.

bank and agency via phone call or email. No US based frozen egg banks returned my request for an interview. Three of the five (60%) of the Canadian agencies allowed me to interview the manager of the agency. These interviews were conducted over the phone.

Fertility patients

I interviewed 20 fertility patients who were going through the process of egg donation or had previously been through egg donation. The interviews ranged from 40 minutes to 90 minutes with the average interview length being about one hour. I only recruited individuals who had undergone egg donation after the *AHRA* was passed as I was interested in how the law shaped their decision making. I used Facebook posts, fertility forums, list-servs, in-person fertility support groups and flyers to recruit participants. I targeted listservs and Facebook groups created for individuals' going through fertility treatment and for new parents. Most boards and Facebook groups required an administrator approve my posts. I also created my own Facebook page that contained information on my research. In addition, I contacted the largest fertility support network in Canada, Fertility Matters, and asked them to distribute my information across their listservs. Local chapters of Fertility Matters then shared my information with members of their support groups. To attempt to recruit individuals from diverse socioeconomic backgrounds, I also posted my flyers in community centers, YMCAs and coffee shops in Ottawa, Montreal, Toronto and Vancouver[20]. I also emailed registered midwives, doulas and acupuncturists and asked them to post my flyer in their offices or to refer me any potential respondents. I created a Meet-Up in Toronto and Montreal and asked other parenting themed Meet-Ups to refer

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[20] This method of recruitment was not successful. I attempted to recruit participants here because I thought that men or individuals who opted-out of fertility treatment may be more likely to find and respond to these flyers as compared to the ad posted on a fertility support group whose membership is mainly composed of current female fertility patients.

participants to my Meet-Up. While my actual event did not attract any participants, one participant did contact me through my Meet-Up page. A few (n=3) participants were recruited through snowball sampling.

Individuals were eligible to be a part of my study if they had gone through fertility treatment or were diagnosed as medically or socially infertile (e.g., gay men) and had been told that they would need donor eggs. Although I did not restrict my sample to women, only women responded to my flyers. The gay men's responses, who may need to use an egg donor for the process of surrogacy, may have been because my advertisement did not specifically address the use of surrogates. Although I attempted to reach out to a few LGBTQ organizations about my study to include this population, these organizations did not respond to my emails. In addition, no heterosexual men responded to my study, further illuminating how fertility treatment is culturally viewed as an individual woman's issue (Almeling and Waggoner 2013).

I used two sets of flyers: one set that specifically targeted recipients who had traveled for egg donation and another set that specifically targeted recipients who stayed in Canada. I attempted to recruit any woman who had travelled for egg donation; however, all but two women who contacted me had traveled to the Czech Republic. While both women had traveled to Mexico, I have decided to not include their data in this dissertation, as their experiences, while not radically different than the women who had traveled to the Czech Republic, took place under a different biopolitical framework and with practitioners that I did not interview.

Eight women who had traveled to the Czech Republic responded to my advertisements and agreed to be interviewed (see Table 2). I call these women "fertility travelers." Although none of my respondents traveled to Spain to receive fertility treatment, I have decided to include the Spanish professionals' responses because of evidence from fertility forums that Canadian women were traveling to Spain, and because of the ways in which clinics in the Czech Republic claimed to model their clinics off of the Spanish system, the largest site of egg donation in Europe (Shenfield et al. 2010). In addition, I was not interested in matching fertility practitioners with fertility patients, but rather better understanding the institutional systems that attracted fertility patients to certain countries. That is, this study does not evaluate the care of specific clinics in the Czech Republic and Spain from the Canadian fertility travelers' experiences, but rather serves to uncover how women make decisions to travel for egg donation as well as how fertility clinics in abroad contexts attract patients to their fertility clinics.

I also interviewed twelve women who had decided to stay in Canada for egg donation. Two of these women used a family member or a friend, two women used a Canadian agency, two women used a US agency and six women used a frozen egg bank. One of the women who conceived using an egg through a frozen egg bank had first tried using her sister's eggs. Since six of these women were currently going through treatment and the outcome of their treatment was uncertain during the first interview, I re-contacted these six women for updates about the outcome of their treatments. Three women agreed to a follow-up interview, one woman wrote a short response about her treatment outcome and two women failed to respond to the follow-up request. I conducted four follow-up interviews with three different women. Overall, I conducted 24 interviews with 20 different egg donor recipients.

The women in my sample underwent 27 egg donor cycles. While most women (n=14) only underwent one egg donor cycle, three women underwent two donor cycles and three women underwent three egg donor cycles. Thirteen of the 20 (65%) women conceived at least one child. Two women conceived twins (1%) and one woman conceived naturally after a failed donor cycle (see Appendix C). Both sets of twins were a result of transfers being done in the Czech Republic and occurred before (2013-4) more recent Czech guidelines had been established regarding the number of embryos to transfer (2016). The rate of successful pregnancy in my sample (13/27; 48%) falls within the expected successful pregnancy rates of egg donation cycles (30-50%) (Society for Assisted Reproductive Technologies 2018).

Like other samples of fertility patients, most participants were white, earned above the average Canadian household income (>$80,000), and were married (see Appendix C). The high earnings and education status of the fertility recipients in my sample reflect the demographics of fertility patients. Women of low socioeconomic status and of non-white ethnicity are much less likely to be both investigated for infertility and treated, partially due to the expense of treatments (Greil et al. 2011b, Tulandi, King and Zelkowitz 2013). Although public funding in Quebec (until 2015) and Ontario have tried to improve access to treatment, none of the women in my sample were able to use provincial insurance to cover the costs of egg donation; either because the coverage no longer existed, the waiting times were too long, or they had already used their one-cycle on a regular cycle of IVF (i.e., a cycle with their own eggs). Even if women had been able to access the coverage in Quebec or Ontario, the programs would have only covered part of the treatment costs as costs for eggs were not covered under the Quebec program and are not covered under the Ontario program.

I asked women to report how much they had spent pursuing egg donation (see Appendix C). Treatment costs ranged from $8,000-$55,000 (mean=$33,600). However, these data are limited as many women did not remember the total costs. Overall, the costs of treatment reported was less for those who traveled to the Czech Republic (see Appendix C). The cost of treatment that the fertility travelers reported does reflect the advertised costs of egg donation in the Czech Republic; however, these costs do not fully represent the total costs of treatment and travel as the amount does not include the amount of money these women and their partners spent on travel itself. When asked about how much money these women spent on travel, most did not know or were reluctant to provide me with a number as they had often combined these trips with their vacations. For women who stayed in Canada and used a known donor, treatment costs were less (~$15,000) as compared to women who used an agency or a frozen egg bank. For those who used a Canadian agency or imported frozen eggs from the United States, the reported treatment costs were over $20,000. These numbers were more difficult for me to verify because of the variability of treatment costs throughout Canada, the lack of information about how much a Canadian or US agency charges, and the various types of frozen egg donor programs.

By using data from both recipients and a variety of fertility professionals, I was able to triangulate my data to ensure that professionals were not providing a skewed version of their practices or experiences. Using data from a variety of sources also allowed me to better understand the process of egg donation from multiple perspectives.

DATA ANALYTIC STRATEGY

I used the qualitative data analysis software RQDA (Huang 2016) to analyze the transcripts. I grouped the transcripts by interviewee type (i.e., recipient or medical professional) and performed line-by-line coding within these categories. Once I developed conceptual codes, I coded for themes both within interviewee type (e.g., recipient vs. recipient) and across interviewee type (e.g., recipient vs. physician). Abductive analysis guided my coding strategy (Timmermans and Tavory 2012).

Abductive analysis demands the in-depth familiarity with knowledge of existing theories, and a close attention to methodological steps (Timmermans and Tavory 2012). In chapter one, I have outlined some of the theories that have guided my analysis. Each empirical chapter also contains information on the perspectives that have informed the thematic codes for which I coded. In determining these codes, I also engaged in a continuous reflective process that allowed me to see how existing sociological and bioethical theories applied or failed to apply to my data. I also wrote numerous memos; this process allowed me to see how codes both came together and contrasted with one another. The focus in this study was not to test existing theories, but rather fitting in "unexpected or unusual findings into an interpretive framework" (ibid 129).

What follows is one example of how I used abductive analysis to draw-out themes from my data: first, I generally examined the interviews for ways in which each professional and recipient understood the *AHRA.* The code "removal of responsibility" was something that arose from the transcripts of the interviews with medical professionals. I then looked for this inductive code across interviews and in the literature to find existing ways that social scientists had described this phenomenon (e.g., boundary-work). I brought those concepts back to the data to see how boundary-work as an "interpretive framework" could enrich my findings (Tavory and Timmermans 2014:129). Since in the literature this concept had only been applied to for professionals and the recipients in my study did not talk about or understand the *AHRA* in the same way, I decided to focus on fertility professionals' use of boundary-work. This decision led me to develop chapter four. The advantage to this kind of abductive analysis is that it allows the data to determine the theoretical concepts used rather than relying on an application of existing theories that may not entirely fit the data.

The following chapters represent some of the key themes that I found in my interviews. The chapters are not an exclusive list of the key themes. However, in this dissertation, I attempt to focus on the ways that the *AHRA* shaped the practices of professionals and the decisions of fertility patients. I then broaden this focus to better understand the development of the global market for egg donation using recipient and professional perspectives, keeping the professionals' and recipients' experiences with these markets central to my analysis. This approach allows me to trace the moral and material consequences of the prohibition on paid egg donation both in Canada and abroad. In the conclusion, I contemplate these consequences and how the perspectives in this research may help inform the future of the *AHRA* and egg donation in Canada.

Table 2 Respondent type and number of Interviews

Interview Type	**Number of Interviews**
Medical professionals[1]	42
Medical professionals in Canada	19 interviews with representatives from 18 clinics
Medical professionals in Spain	10 interviews with representatives from 10 clinics
Medical professionals in the Czech Republic	13 interviews with representatives from 8 clinics
Fertility professionals	32
Counselors	18
Lawyers	11
Egg banks	3
Recipients	24
Fertility Travelers	8
Recipients who stayed in Canada	16 interviews with 12 participants
Total	**98**

1. Medical professionals include egg donor coordinators, physicians and nurses.

Chapter 4
“It’s my job to get the egg and sperm together”: Boundary-work in Canadian egg donation

“My job is I can get the eggs and sperm together, I can put it in the uterus to make it happen” (physician, clinic 6)

Chapter 2 explains how the *Assisted Human Reproduction Act (AHRA)* changed the practice of egg donation from one that the medical professional solely oversaw to one that a national law regulated. This chapter empirically examines how this law shaped Canadian fertility professionals’ practices, focusing on how medical practitioners attempted to distinguish their work from other fertility practitioners, including lawyers and counselors. It provides Canadian fertility practitioners’ perspectives surrounding what they see as the material and moral consequences of the *AHRA* on their own practices. Ultimately, I argue that medical practitioners attempted to remove themselves from these ethical and now legal concerns by using boundary-work (Gieryn 1983). Boundary-work is the social process by which scientific and medical professionals use their knowledge of “science” to distinguish their tasks from non-scientific pursuits. In using boundary-work, medical practitioners narrowly defined their “scientific” role in egg donation, removing themselves from the ethical and legal debates surrounding donation.

THIS IS MEDICINE: A THEORETICAL INTRODUCTION TO BOUNDARY-WORK IN MEDICINE

Gieryn (1983: 781) describes “boundary-work” as work that discursively and materially demarcates different groups’ tasks, allowing for the pursuit of professional goals such as “protection of the autonomy of scientific research from political interference.” This boundary-work often involves claiming areas of knowledge as belonging to one's profession and removing other more politically or socially contested roles. These knowledge claims, Abbott (1988), Gieryn (1983, 1995, 1999), and Whooley (2013) suggest, are important for defining a profession. While Abbott (1988) argues that the knowledge claims professions rely on are static, Gieryn (1983, 1999) shows how the reliance and definition of certain knowledge as "scientific" is contextual, flexible and historical. Boundary-work can protect the activities of the profession "exempt[ing] members from responsibilities for consequences of their work and by putting the blame on scapegoats from the outside" (Gieryn 1983:792). Although Gieryn (1983) uses the profession of science to illustrate the concept of boundary-work, this concept can also be extended to those involved in the practice of science (i.e., medical practitioners) (see Lindberg, Walter and Raviola 2017).

Boundary-work allows scientists to rhetorically remove their scientific practice from the consequences of their work, allowing others to be held responsible (Gieryn 1983). Hughes (1962) described the undesirable/morally contentious tasks that outsiders are asked to do as "dirty work." Hughes' original conceptualization of "dirty work" described the ways "good people" allowed others to do their morally contentious work to maintain their own social status. The broader sociological literature has primarily focused the concept of dirty work on stigmatized groups who perform physically tainted (e.g., washing patients, cleaning bed pans, etc.) or morally and socially tainted (e.g., abortion) tasks (Bolton 2005, Harris et al. 2011, O'Donnell, Weitz and Freedman 2011), rather than on how other professions may use knowledge claims to remove themselves from ethically contentious work (for an exception see Suh 2014). These conceptualizations overlook how dirty work can also function to ensure the continued workings and status of a profession.

In this chapter, I use Hughes' (1962) conceptualization of "dirty work" as morally contentious work to define the ethically and legally contentious aspects of egg donation as the dirty work of donation. This work is considered "dirty" because of the continued political debates within Canada of what is and what is not considered ethical altruistic donation (see Housefather and Cohen (2018)) as well as the *AHRA's* criminalization of paid egg donation. I examine how fertility professionals engage and/or distance themselves from these debates and the potential consequences of the *AHRA*. While Gieryn (1983) suggests that scientists often mobilize their specific knowledge to remove themselves from political conflicts, leaving scapegoats to absorb the conflict, I examine how those who engage in the dirty work of donation, the "scapegoats," may also be able to make knowledge claims as they are willing to engage in the ethically and politically contentious work.

Previously, Cadge, Ecklund and Short (2009) described how physicians use "boundary-work" to negotiate religion and spirituality within their counseling of patients' end-of-life decisions. Other scholars have used it to describe allopathic medical practitioners' relationships with alternative medicine practitioners (Derkatch 2008, Mizrachi, Shuval and Gross 2005), imaging technologies (Burri 2008, Lindberg, Walter and Raviola 2017) and to differentiate their work from others within the medical profession (e.g., nursing-work from physician-work) (Allen 2000, Liberati 2017, Liberati, Gorli and Scaratti 2016). These works focused on how allopathic physicians mobilize particular scientific knowledge in order to distinguish their tasks from other health care professionals, showing how the medical profession claims its "intellectual authority" (Gieryn 1983:781) over the practice of scientific medicine. In doing so, the medical profession distinguished its activities from other "quack" professionals (Whooley 2013). Timmermans and Berg (2003) note how the reliance on science in the practice of medicine intensified with the rise of evidence-based medicine. This previous research on boundary-work in medicine shows how physicians and other medical practitioners mobilize and define scientific knowledge to determine their professional practices.

While research on boundary-work in the medical profession primarily examines how medical practitioners mobilize scientific knowledge to claim professional authority, it does not examine how medical practitioners may mobilize scientific knowledge to remove their practice from legal and ethical scrutiny. Instead, it focuses on the ways that allopathic physicians use scientific knowledge and technologies to demarcate their work from other less-established medical practitioners (see Lindberg, Walter and Raviola 2017, Mizrachi, Shuval and Gross 2005). With the rise of new biotechnologies and regulations on their use, examining how medical practitioners respond to regulations is important for understanding what activities are and are not considered (scientific) medical activity (Wainwright et al. 2006). This interrogation has important implications for upholding the status of the medical profession as those who practice science “downstream” (e.g., medical practioners) often use scientific knowledge to “stand metonymically for credibility” (Gieryn 1999:ix-1). In vitro fertilization technologies involving egg donation, allows for this examination as regulations attempt to restrict the scientific research and medical practices that constitute the medical practitioners’ work.

Boundary-work in fertility treatment

In describing how scientists involved in embryonic research negotiate regulations and ethics within their practice, Wainwright et al. (2006) argue that these labouratory scientists are increasingly engaging in “ethical boundary-work,” incorporating the non-scientific practice of “ethics” into their profession. By incorporating ethics into science, the authority of non-scientific regulatory bodies is enhanced, and the scientists’ work is de-privileged (Wainwright et al. 2006).

Using the concept of “ethical boundary-work,” Wainwright et al. (2006) expand upon Gieryn’s (1983) definition of boundary-work to show how ethics has become a part of everyday scientific practice. While Wainwright et al. (2006) explore how scientists outside of the fertility clinic negotiate new regulatory frameworks regarding the development of new reproductive technologies using ethical boundary-work, Ehrich et al. (2006) examine how fertility clinic staff balance their own views, the welfare of the child as defined by the state, and the capabilities of science. These negotiations, they argue, rely on “ethical boundary-work” in which fertility clinic staff present themselves both as ethical and scientific-expert actors.

Both Ehrich et al. (2006) and Wainwright et al. (2006) suggest that these distinctions between ethical and non-ethical scientific and medical practices are a result of the rise of new biotechnologies; however, they overlook how the negotiation of ethical practices within science is not new, but rather was codified as part of scientific activity with the Nuremberg Code (1947) and the Declaration of Helsinki (1964) (Paul 2017), and medical activity with the Hippocratic Oath (Freidson 1970). Thus, the incorporation of ethics into scientific and medical activity may not be a challenge to professional authority of fertility scientists or medical practitioners, but rather a continuous negotiation process whereby scientists and medical practitioners accept or reject ethics to justify their claims to authority. They also fail to consider how, in incorporating ethics into the practice of science, these scientists and medical practitioners engage in flexible knowledge claims that allow them to reject and/or accept outside regulations if these laws benefit their professional status as scientists. Thus, the claim to “ethical boundary-work” that both Ehrich et al. (2006) and Wainwright et al. (2006) make does not fully examine how scientists and medical practitioners negotiate ethics, claiming certain types of knowledge and rejecting others.

This research on boundary-work is also limited in context as it only examines the regulatory context of the United Kingdom. As boundary-work is dependent on context, it is also important to examine how medical practitioners in different countries may respond differently to political regulations and consequences of their practices (Gieryn 1983). In this chapter, I examine how fertility clinic staff in Canada incorporate or remove ethical knowledge from their practices after the passing of the *ARHA*, which criminalized a specific practice.

This chapter further explores the tensions between regulatory frameworks (i.e., the *AHRA*) and fertility technologies and how the addition of other non-medical fertility professionals may allow for medical practitioners to reclaim their allegiance to scientific rather than ethical knowledge. In examining how medical practitioners negotiate science and ethics, I examine if fertility medical practitioners engage in "boundary-work," defining non-scientific activity as outside of their profession and therefore, "dirty," or if medical practitioners engage with ethical and legal controversies, practicing "ethical boundary-work" (Ehrich et al. 2006, Wainwright et al. 2006).

I find that medical practitioners used boundary-work, relying on interpretative strategies that aligned their work with science and defined other dirty work as non-scientific. In defining contentious work as outside of their practice, they upheld their practices against the threat that the *ARHA* posed to egg donation. Protection of authority, Gieryn (1999: 17) argues, is a kind of boundary-work that occurs when certain practices are under political threat, allowing that profession to remove themselves from blame by relying on others.

AVOIDING KNOWLEDGE

While the *ARHA* prohibited the payment for egg donation, it did not mandate that fertility clinics rely on other fertility professionals to find and recruit donors. However, fertility medical practitioners saw the potential threat that the act placed on their status and began to draw boundaries around their clinics' practices. An egg donor coordinator explains the changes her clinic made in response to the legislation,

> So, if somebody brings a donor or a carrier, they all have to have legal advice and they all have to have a contract in place or an agreement in place, whatever you want to call it, which we didn't get into before. We didn't get into the legals before [the *AHRA*].

These contracts theoretically defined the altruistic relationship between the donor and recipient as well as allowed medical practitioners to remove themselves from any discussion surrounding payment of the donor. The contracts that the coordinator discusses are a result of the fertility clinics' mandating their patients provide a contract rather than a direct mandate of the *AHRA*.

While legislation can set the stage for a change to medical practice, it does not necessarily mean that other professionals will be incorporated into medicine. For example, Canadian legislation that requires the informed consent of patients before medical procedures or research trials (e.g., Health Canada 2014) did not result in every patient or participant seeing a lawyer for an individual contract. Instead, medical practitioners use a standardized consent form across patients. The case of egg donation differs from these other consent processes in that clinics require a lawyer to create an individual consent forms and for every patient to sign it. Thus, in most other cases, medical practitioners communicate with their patients about extra-medical and extra-scientific consequences of the procedure (Hall, Prochazka and Fink 2012), incorporating non-scientific activity into their practice to abide by these regulations of consent.

The flexibility of medical practitioners to perform boundary-work by defining what is considered medical practice is reflective of Gieryn's (1983:792) original definition of boundary-work, which suggests that boundaries drawn are "flexible" and dependent on "context." The *ARHA* has different repercussions for medical practitioners than other similar regulations surrounding medical activities. A physician explains these repercussions, “The problem with the law is that it is punishable by ten years in jail…And so, I’m like hang-on. I’m a professional” (clinic 03). Thus, the removal of their practice from the legal aspects of egg donation served a specific function for medical practitioners. In claiming that they were not knowledgeable of the law, medical practitioners removed themselves from the legal aspects of egg donation, relying on their knowledge of the “scientific practice” of egg donation. The unwillingness to engage in these egg donation contracts, but the willingness to engage in other legal contracts in different contexts, shows the flexibility of medical practitioners’ knowledge. In this case, the *AHRA* is the “structural context” (Gieryn 1995, Strauss 1978), which shaped medical practitioners’ claims to knowledge in that the potential for medical practitioners to be criminally charged, potentially caused them to disengage from egg donation activities they previously performed, and define this work outside of their practice.

Fertility professionals not only attempted to remove themselves from the process of finding an egg, but they also actively acknowledged that they did not want to know about what agreement their patients made with potential donors. A doctor explained how he avoided the subject of contracts with his patients:

> But you’d have to be naïve to think that everyone who comes to your office with their newest best friend doesn’t have some kind of arrangement and whether that some kind of arrangement is completely above board or not, I don’t know. It’s analogous to, quite frankly, what you used to have in the US with gays in the military. It’s “don’t ask don’t tell.” So, if a patient comes in and says this is my friend. I’m just going to say, “I just want you to be aware that it is illegal to pay for eggs in Canada.” They all nod their heads and [laughs]. Okay. You’ve been informed (clinic 09).

In defining their role as outside of securing a fresh or frozen egg, medical practitioners established the boundaries of their knowledge and defined their job as “get[ting] the eggs and sperm together” (physician, clinic 06). In drawing boundaries between the medical practice of egg donation and the discussions surrounding compensation, medical practitioners distanced themselves from any knowledge of the egg donation contract. This claim of lack of knowledge may have potential implications on egg donors as the medical professional may not be able to fully discern if the consent is free from undue inducement.

FINDING DONORS AS OTHERS' WORK

Before the *AHRA* came into place, fertility medical practitioners in Canada found and recruited donors, meaning that there were no boundaries between recruiting donors and stimulating donors. After the passing of the *AHRA*, all but one clinic in my sample stopped recruiting donors. A physician explains, "So we just say that if you really want to and you can't find a donor yourself…these are the agencies and you can approach them" (clinic 09). In referring his patients to an agency, this doctor simultaneously acknowledges the practices of these agencies, while removing himself from the dirty work they perform.

The dirty work that these egg donation agencies performed was done in different ways, either by matching a potential recipient with a "fresh" donor or by facilitating the shipment of frozen eggs from the United States to Canada. Both types of egg agencies dealt directly with the costs of the cycle, often determining what is and is not considered reimbursable expenses—"we've extrapolated [what] those expenses would be…. Obviously, we just reimburse for the expenses" (agency representative, bank 03). Here, the representative attempts to justify the reimbursable expenses that they provide Canadian donors by referring to recommendations outside of Canada. Another egg bank enforced a rule of "spreadsheets" to document "receiptable expenses" (agency director, bank 02) to tie the amount of money given to a donor directly to the expense the donor incurred. This documentation helped the known egg donor agencies justify the payment given to the donors as reimbursable expenses. Discussions surrounding compensation were quickly followed by the altruistic aspect of the donors' intentions whereby donors were seen to be "givers by nature" who had "big hearts and want to help" (agency director, bank 03). The altruistic "nature" of donation is not only promoted by the *AHRA*, but is a highly gendered phenomenon where social expectations of "giving women and mothers" map onto ideas surrounding the ideal donor (Almeling 2011). In constructing donors as purely giving, egg donation agencies who worked directly with donors rhetorically upheld the *AHRA* and social expectations of femininity.

Canadian egg donation agencies also drew boundaries around their work to preserve their legitimacy. Just as medical practitioners relied on discourses of science to define the boundaries of what work they would and would not engage in, agencies mobilized discourses of family building. The head of an egg agency states, "It is really about helping people and getting them to be successful and reaching their goal of building or adding to their family" (bank 02). Constructing donors as giving was a way that egg donation agencies managed their dirty work in that they maintained the appearance of complying with the law, reframing their agency not as a broker (in direct contradiction of the *AHRA*), but as an agency that helped "create families." Through the narratives of altruism and family building, the agencies created new "esteem-enhance[d] social identit[ies]" (Ashforth and Kreiner 1999) by defining the egg donation process as "empowering" to young women, and seeing their work as ultimately "helping people produce families" (agency director, bank 02). Producing new "esteem-enhancing social identit[ies]," Ashforth and Kreiner (1999) argue, is a way that workers in "dirty" occupations may justify their work to outsiders. They constructed themselves as a service that families can purchase to ensure that they are protected and guided through the altruistic egg donation process rather than an illegitimate broker who helps intended parents find illegal paid-for eggs.

Although egg agencies attempted to define their practices as legally permissible by aligning themselves with narratives of family building, they were not always seen as legitimate. This meant that only seven of the eighteen clinics (38.9%) I visited allowed for patients to use a donor from one of these agencies. A physician explained why his clinic refused to work with agencies: “those agencies I think really work on the very grey line of whether they’re strictly okay or not okay in Canada. I’m not a judge or a jury, I’m not going to comment on that, but they are in that kind of grey zone” (clinic 11). Thus, the professional identity that these agencies created only worked so far in that some, but not all, clinics deemed their services as legitimate even though only one agency has ever been prosecuted. While medical practitioners acknowledged that the ways these agencies operated could be ethically contentious, they routinely claimed that they were not “judges” or “juries” who could determine the legality of these agencies. Instead they actively avoided these agencies, and in the process delegitimatized the agencies’ professional status. The ability to refer to lawyers when medical practitioners did not want to get into the “legals” and to decide which fertility agencies they would work with shows the ways the medical practitioners were able to negotiate the ethical aspects of donation. In other words, medical practitioners used the limitations that the *AHRA* created to structure the practice of egg donation so that they remained in control of the practice, but outside of legal ramification.

OUTSOURCING KNOWLEDGE

Medical practitioners did not only remove themselves from these discussions, but also outsourced the entire process to US frozen egg banks. A physician at a large fertility clinic, explained that their clinic was not involved in paying for or finding frozen eggs, “So we are not a broker at all. So, they [the patients] pay the clinics that ship us eggs. So, all we do is the *medical* part. That’s all” (emphasis mine, clinic 13). Thus, this physician, like other medical practitioners in my sample, established his role as exclusive to the more medical part of the process, the transfer. In doing so, medical practitioners treated frozen eggs as medical devices or parts, claiming that their role was to “transfer” the egg to the patient. At the same time, this claims-making removes some of the medical aspects of egg donation from the Canadian medical practitioners in that they relied on US medical practitioners to stimulate and retrieve the eggs from the donor, allowing other medical practitioners to do a medical procedure in a different context (a context, albeit, that allowed for payment). This claims-making shows how context matters in drawing the boundaries of what is and is not considered a medical practice.

While agencies that worked with fresh eggs used the concept of “reimbursable expenses” and the language of altruism to attempt to uphold the legitimacy of their practices, frozen egg banks relied on national borders. When I asked the owner of an egg bank who works with Canadian intended parents, if the egg donor received any type of money, he responded by stating, “we’re not paying the donors. Our suppliers [in the US] that recruit the donors, stimulate the donors and retrieve and freeze the eggs are the ones that are actually paying the donors” (bank 01). This director acknowledges that donors were paid, but that the *AHRA* could not restrict this payment as it occurred outside of the law’s jurisdictional boundaries. In this case, payment for egg donation was not seen as something that conflicted with the law but was rather outside of the law’s reach. Moreover, since the egg bank itself did not pay the egg donor directly, medical practitioners redefined the banks as “clearing house[s]”—

> The way Donors “R” US actually works is it is a conglomerate of a whole bunch of clinics. And all of those clinics have individually paid the donors. So technically the clinics have paid the donors, and Donors “R” US has like a clearing house of all these clinics. So, Donors “R” US, itself, has technically not paid the donors. Donors “R” US, then gets paid by the [Canadian] recipient but because Donors “R”

> US hasn't paid the donor it makes it somewhat legal (egg donor coordinator, clinic 05).

Frozen egg banks used national boundaries and business intermediaries to legitimize their businesses within the *AHRA*. The success of these agencies in entering the egg donation market is determined by the uptake of their services by Canadian fertility clinics. Although these agencies are relatively new and the effectiveness of using frozen eggs is still controversial (Cobo and Diaz 2011), twelve clinics (66.6%) reported using frozen egg banks as a source of eggs, and two more clinics said they were in the process of securing contracts with egg banks in the United States. In addition, clinics who used these banks reported that their patients were more likely to use these services as compared to a known donor.

The differences in defining acceptable and unacceptable eggs is partially based on the eggs' location. This differential valuation creates divisions in the market where not all goods have the same "moral meaning" (Anteby 2010). In the case of Canadian egg donation, frozen eggs imported from the US have a perceived different moral and legal meaning than fresh eggs from Canadian donors, even though both can be used in the same procedure, are viable options for achieving pregnancy, and require the same medical risks to be taken by the donor. Medical practitioners, acting as medical gatekeepers, largely created the frozen egg market by referring their patients to specific agencies while sometimes neglecting to mention other ways of finding eggs.

A fertility counselor explained to me the consequences of this type of gatekeeping—

> one thing I'll do is I'll say, "were you [the patient] aware that there were other options." And if they say, "no, what do you mean?" Then I'll say, "I, we don't

> have to talk about it, but I want to let you know that that isn’t the only option (counselor 02).

This counselor saw medical gatekeeping as a problem because it potentially limited options for pursuing egg donation, not because these other options were less effective or illegal, but because of the preference of medical practitioners to work with different methods. Medical practitioners, and not law makers, played an active role in determining what types of egg donation was and was not considered legal in the context of the *AHRA*. The legitimization of certain types of practices considered as moral by specific professionals is not unique to egg donation as life insurance agencies and cadaver sales agents have all used particular narratives in order to establish a “professional view of moral legitimacy” that justify their practices within legal guidelines (Anteby 2010:610, Zelizer 1979).

However, while Freidson (1970) argues that professions will voice their views of moral legitimacy to maintain their jurisdictional authority, medical practitioners attempted to claim neutrality using boundary-work to separate their “medical decisions” from political decisions regarding egg donation. This separation was not due to medical practitioners’ ignorance of the ethically tainted work of egg donation, but rather an active disengagement from the knowledge of compensation and the *ARHA*. For example, when I asked a physician (clinic 17) how she felt about the ability to compensate donors, she claimed that she is “not a very political beast,” actively removing herself from larger political discussions regarding egg donation while simultaneously ignoring how, in practicing certain types of egg donation, she determined the legitimacy of those practices.

DRAWING BOUNDARIES AROUND EMOTIONS

Medical practitioners also detached from another process of egg donation, the discussions surrounding intended parents' feelings of using an egg donor, the emotional work of donation. They often defined these issues as work for counselors or social workers—

> I can get the eggs and sperm together, I can put it [the embryo] in the uterus to make it happen, but beyond that there are broader implications, you know what happens later in life….so these social workers work with fertility patients. (physician, clinic 18)

Medical practitioners actively removed themselves from ethical debates surrounding the use of an egg donor by referring their patients to another allied professional. One doctor explained how her patients were required to seek legal and psychosocial counsel before continuing with egg donation, "so they [the intended parents] and the donor have to meet with the lawyer and have the legal documentation, which we need a copy of……and they have to go through counseling" (clinic 04). The incorporation of non-medical bodies such as fertility counselors and lawyers into fertility medicine is not unique as Starr (1982) suggests that medicine has transformed from a body consistent of solely medical practitioners to one that incorporates other allied health professionals. Starr (1982) argues that this dependence on other fertility professionals highlights the specialized knowledge and skills of a specific profession in relationship to other professionals rather than posing a direct threat to the medical profession. Medicine's professional sovereignty comes not from its ability to control entire life processes but to be able to define and control what it considers as medical knowledge.

After the passing of the *AHRA* physicians began to define psychosocial questions (e.g., disclosing the child was donor conceived) as outside of their practice. For example, when I asked a physician if his patients intended to tell their offspring how they were conceived, he stated,

> I don’t know what the people tend to do. Now there is a body of research that looks at that [disclosing to the future child]. But you know there is a contact that would know that better. Which is the psychologist (clinic 16).

The redefinition of psychosocial issues as outside of medical practice may have been due in part to another aspect of the *AHRA* which attempted to protect the “health and well-being of children born through the application of assisted human reproduction technologies” and the “health and well-being of women” (*Assisted Human Reproduction Act* 2012). So although physicians were concerned with their patients’ health, they left questions of well-being of future offspring to counselors potentially in part to remove themselves from ethical quandaries that arose during the procedure in favor of a technical definition of their work.

This practice of removing psychosocial factors of medicine is reflective of Cartesian mind-body dualism where medicine takes care of the body (i.e. the infertility problem) whereas the mind exists outside of medicine (Descartes 2008 [1647]). The drawing of the boundary of the physician and the counselor reflects this division as medical practitioners performed the medical aspects of egg donation while the counselor performed this emotional work. The counselors’ work was to prepare the mind for the medical intervention done to the body. That is, the counselor was to make sure the patient could undergo the effective therapy for female-factor infertility. However, the patient did not always accept this solution as they “want a biological child. And even if it’s not that they want a biological child, they feel uncomfortable with a husband’s sperm fertilizing another woman’s egg” (counselor 06).

After the passing of the *AHRA*, counselors were increasingly called upon to facilitate the "rational" treatment of egg donation, helping patients overcome the "irrational" fear that they could not love a non-genetically related child. A physician explained that the

> biggest thing is the decision-making. But often once they've [the intended parents'] wrapped their head around it and they're ready to go, often they can get their counseling, their preliminary work done and have the eggs shipped and get them on their way fairly quickly (clinic 13).

The dirty work that medical practitioners asked counselors to do relied on a form of gendered emotional labour where the women counselors were expected to manage patients' emotions (i.e., their mind) towards egg donation so that the medical procedure could continue (on the body). In doing the dirty work of emotional labour, counselors allowed medical practitioners to draw boundaries around their practices, referring their patients to counselors instead of attempting to go through the pros and cons of donation with their patients. In other words, physicians left the responsibility of ensuring the woman's "well-being" to the counselors.

Since gendered stereotypes of women often presume that women are innately able to monitor their own and others' emotions, women are more likely to occupy positions that require emotional work as compared to men (Hochschild 1983). Thus, it is unsurprising that all of the fertility counselors in my sample were women (18/18; 100%), contrasted to the physicians in my sample who were composed of mainly men (11/16; 68.7%) (see Table 3). Additionally, lawyers who were often engaged in another type of emotional work—managing donor and intended parents' needs through a legal contract—were also mainly women (9/11; 81.2%). The fertility counselors and lawyers' performance of emotional work facilitated medical practitioners' ability to practice medicine, as they no longer had to ensure that the intended parents were psychologically ready for donation.

Counselors removed themselves from the final decisions surrounding donation by drawing boundaries between their role as counselors and medical practitioners' roles of deciding who could go through with the donation. A fertility counselor, explains, "I'm not a gatekeeper and I don't feel like I have the right in any capacity to say who can become a parent…who am I? I am not God" (counselor 04). While counselors would voice their concerns to the medical practitioners if the "woman hasn't got over the ideas of not being biological and she is concerned that she won't love this child" (counselor 04), they ultimately left the final decision up to the medical practitioners. In removing themselves from the final decision regarding the donation, counselors both questioned the paternalistic practice of "approving" a patient based on their current mental health status to undergo donation and privileged scientific medical knowledge in that it was the biological ability to sustain a pregnancy rather than the psychosocial health of the intended parents that was ultimately seen as allowing for donation. This finding is similar to work surrounding professional jurisdiction between doctors and nurses where nurses' "in-depth" knowledge is often taken into consideration, but the final decision rests with the physician (Liberati 2017, Xyrichis, Lowton and Rafferty 2017). In privileging biological capacity, counselors contributed to the authority that the medical practitioners held over egg donation in that the procedure was ethically, emotionally and legally permissible as long as the medical practice of egg donation was viable. In this case, the "well-being" and "health" of the woman, that the *ARHA* demanded, was closely aligned with her body rather than her psychosocial health.

PROFESSIONAL ORGANIZATIONS

Medical practitioners engaged in boundary-work by creating social boundaries between their work and the dirty work of lawyers and counselors, and also developed organizational boundaries to ensure the separation of their roles from that of lawyers and counselors (Lamont and Molnar 2002). This organizational boundary-work is further exemplified through the formal professional organization (Canadian Fertility and Andrology Society (CFAS)), whereby other professional groups are "invited" to join the interdisciplinary society. Although other professional groups are invited to CFAS, physicians solely determine the rules and guidelines of the society, who hold the majority of board positions and the ability to vote (counselor 18). This separation of voting and non-voting members creates a symbolic boundary between fertility physicians and counselors, marking physicians' authority and continued control over the egg donation process. It also confirms the claim that in spite of efforts to "modernize" the medical system, the incorporation of additional professionals results in a "more conservative [and gendered] redistribution of power and responsibility" than previously thought (Martin, Currie and Finn 2009:1191).

Distinguishing their role from other fertility professionals meant that medical practitioners often described their role as seeing patients, diagnosing them and providing treatment. In doing so, medical practitioners aligned their practice with scientific knowledge surrounding fertility, often showing me graphs and egg donation facts that stressed the scientific validity of egg donation as a medical solution for infertility. The reliance on empirical data and the removal of their practice from the process of finding an egg and counseling their patients is consistent with Gieryn (1983)'s conceptualization of boundary-work; the constructions of boundaries around one's activity to define professional autonomy.

DISCUSSION

Although the *AHRA* potentially threatened the practice of egg donation within Canada as it created criminal consequences for those who did not abide with the act, Canadian medical practitioners were able to remove their practices from the dirty work of donation by using scientific and medical knowledge claims to draw organizational and symbolic boundaries around their work. This drawing of boundaries resembles Gieryn's (1983) original conceptualization of boundary-work as medical practitioners diverted ethical and legal issues to other (women) fertility professionals.

The professionalization literature notes that knowledge claims are important for establishing a profession (Abbott 1988), but largely ignores how knowledge claims can change according to context (Whooley 2013). By using the concept of boundary-work, I show the importance of context in determining the types of knowledge that medical practitioners will claim. I explain how regulatory threats such as the *AHRA* change the knowledge claims that medical practitioners make. I demonstrate how medical practitioners responded to the *AHRA* by relying on medical and scientific boundaries to more clearly demarcate their tasks from others. This finding contributes to Gieryn's (1983: 792) original conceptualization of boundary-work by showing how in the medical practice of transnational egg donation, like science, the boundaries are "ambiguous, flexible, historically changing, [and] contextually variable."

The ability to selectively draw on scientific knowledge rather than legal, emotional or ethical knowledge allows medical practitioners to reclaim autonomy and authority over egg donation. This chapter adds to the literature on the use of boundary-work by medical practitioners by showing how those who practice science "downstream" also draw on scientific knowledge to engage in boundary-work (Gieryn 1999:ix). Just like scientists who relied on certain practices and discourses of science to uphold their status in the face of religious and political threats (Gieryn 1983), medical practitioners used medical and scientific knowledge claims to distinguish their work from dirty work of donation, upholding their profession against the threat of the *ARHA* (Gieryn 1999:16, ftnt 21). I argue that boundary-work is an effective strategy that medical practioners use to uphold their status. I combine literatures on boundary-work, professionalization and dirty work to show how boundary-work is an effective professionalization strategy as it allows for various knowledge claims to be mobilized to distinguish undesirable tasks (i.e., dirty work) from the work of the profession.

Unlike Ehrich et al. (2006)'s finding that clinicians actively mediated ethical issues by engaging in ethical boundary-work to weigh their scientific knowledge with the public's opinion, I found that medical practitioners were more likely to remove themselves from the dirty work of egg donation by claiming that these tasks were outside of their knowledge-base. This type of boundary-work is more effective than ethical boundary-work in that it clearly delineates ethics as outside of medicine. It establishes the purview of a particular profession and, in this case, ensures that medical practitioners are not held legally or ethically responsible. Thus, the medical practitioners were left to perform treatment while other non-medical practitioners debated if this treatment was ethical and legal.

This chapter shows the ability of the medical profession to maintain its continued authority by the drawing of boundaries of scientific and non-scientific activities. I do this by highlighting the ways fertility medical practitioners were able to maintain control over egg donation despite potential challenges to their authority. Medical practitioners used their knowledge of science to negotiate the “collaborative relationships” with other fertility professionals in order to maintain their power (Nugus et al. 2010). These collaborative relationships shifted the burden of the dirty work to other professionals so that the medical practitioners were further removed from ethical or legal considerations. This boundary-work simultaneously allowed the medical profession to uphold its public image and ensured that the medical practice of egg donation could continue to occur despite the legal and ethical threats of the *AHRA.*

In the next chapter, I turn to women’s experiences with the *AHRA*, showing how the *AHRA* fails to fully conceptualize the types of exchanges that can take place even within an “altruistic” system. I argue that the distinction that the *AHRA* attempts to create between the egg as gift and egg as a commodity through the prohibition of paid egg donation fails to fully consider how eggs can be treated as commodities *even if* money is not exchanged for eggs. I analyze the relationships that are created within these exchanges and illuminate the processes of labour that allow eggs to be given and sold.

Table 3 Gender distribution of Canadian professionals

Type of Professional	*No. of Men (%)*	*No. of Women (%)*
Medical Professionals		
Physician (n=21)	15 (71.4%)	6 (28.6%)
Embryologist (n=2)	0 (0%)	2 (100%)
Donor/patient coordinator (n=9)	1 (1.1%)	8 (98.9%)
Nurse (n=3)	0 (0%)	3 (100%)
Clinic manager (n=7)	3 (42.9%)	4 (57.1%)
Total (n=42)	19 (45.2%)	23 (54.8%)
Fertility Professionals		
Lawyers (n=11)	2 (18.1%)	9 (81.2%)
Counselors (n=18)	0 (0%)	18 (100%)
Egg bank managers (n=3)	2 (66.7%)	1 (33.3%)
Total (n=32)	4 (12.5%)	28 (87.5%)
TOTAL (N=74)	**23 (31.1%)**	**51 (68.9%)**

NB. I provide the gender distribution of the professionals for information. However, I am not able to ascertain if these gender distributions are reflective of the larger professional categories.

Chapter 5
"I would want to pay her": Ethical ambiguities in "altruistic" egg exchanges in Canada

"I would want to pay her…Part of me would want to pay her for it. She's working for me."

—Martha

In chapter 2, I discussed how Canadian biopolitics affect the pathways by which Canadians obtain an egg (see Figure 1). The pathways that my respondents used to find an egg include using a known donor (i.e., a family member or friend), using a donor recruited by a Canadian agency, using a frozen egg imported from the United States, or exiting the Canadian system by traveling abroad. These pathways are arguably a result of the *AHRA*, which prohibits the payment of egg donors, limiting the number of willing Canadian egg donors. The intention behind the prohibition was to prevent "trade in the reproductive capabilities of women and men and the exploitation of children, women and men for commercial ends" in order to protect the "well-being of women" (*Assisted Human Reproduction Act* 2012: s2). In other words, the *AHRA* attempted to prohibit the commercialization of egg donation by prohibiting the "trade in" or the market for eggs.

This chapter explores how the *AHRA* did not, in fact, prevent the "trade in" eggs as the supply and demand for eggs continued (and continues) to exist even within Canada. Instead, the

AHRA's prohibition shifted the market from a legal to a "grey market"[21] (Ertman and Williams 2005) where the purchasing (but not selling) of eggs was criminalized. While the criminalization of paid egg donation is morally preferable for some (see Royal Commission on New Reproductive Technologies 1993) in that it intends to prevent the exploitation of women, I argue that this practice overly simplifies the relationship between gift exchange, commodification, and (im)morality. As a result, the material and moral consequences of the market limits placed on these exchanges have been largely overlooked (for exception, see Hammond 2015). Instead of focusing on the "victims" (i.e., potential donors) of the market, I suggest that we look to the current state of egg donation within Canada to more completely understand the power imbalances that have emerged within this gray market.[22] More specifically, I argue that the false dichotomy between gift/market exchange limits our understanding of undue influence, hides reimbursable expenses behind the language of gifts, assumes that money for eggs creates a free market, and fails to recognize women's reproductive labour[23] in donating their eggs. In rejecting the gift/commodity dichotomy, I call for a new perspective on viewing eggs as both gifts *and* commodities, existing within social and monetary relations of power.

MARKETS AND BODY PARTS: A THEORETICAL INTRODUCTION TO GIFTS AND COMMODITIES

This section provides a theoretical background to the various frameworks and discourses that have shaped egg donation. I first describe the ways in which scholars have situated debates surrounding the ethical exchange for eggs within the gift/commodity dichotomy. I then describe

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[21] A grey market is a market where a good (e.g., eggs) is traded outside of normal means, but this trade is not always considered illegal.

[22] This examination follows Radin (1987)'s call for a case-by-case analysis of commodification rather than a blanket statement that all commodification is immoral.

[23] Reproductive labour refers to the labor involved in (re)producing a family, including procreation, housework, childcare, etc. (Marx 1978 [1844]).

how some feminist theorists have begun to disrupt this framework. Finally, I argue that eggs should be thought of as both gifts and commodities.

In analyzing the exchange of body parts and gametes, social scientists and philosophers have relied on the gift/commodity dichotomy (Strathern 1984). Zelizer (2000) has suggested that this duality relies on a "hostile worlds" approach where gifts are viewed as opposite of (immoral) commodities. Those that see gifts as the preferable method of exchange argue that in allowing body parts to be sold on the market, the autonomy of the individual is necessarily challenged (Andrews and Nelkin 2001, Baylis and Downie 2014, Constable 2009, Gupta 2012, Kimbrell 1997, Motluck 2010, Scheper-Hughes and Wacquant 2002, Scheper-Hughes 2000, Spar 2006, Titmuss 1970). They often highlight the economic and social disparities between those who are paid to donate their body parts and those who can purchase their goods (Scheper-Hughes 2000). In these arguments, there is often an underlying assumption that by putting a price on life, persons and the relationships between persons become commodified and that this commodification is ethically wrong (see Scheper-Hughes and Wacquant 2002).

Those who approach the market for donor gametes and body parts from a liberal perspective offer an alternative view. This perspective often highlights that the ability to pay a donor increases the supply of donors because payment may increase the incentive for a donor to undergo the troubles of donation (i.e., taking time off work, traveling to a clinic, and possibly experiencing pain and side effects) (Shanley 2002). They often suggest that it is morally wrong to remove an opportunity for a person to participate in a market for bodily goods, especially if that participation is better than the alternative (i.e., starvation, inability to provide for her family) (Pence 2008, Posner and Landers 1978). However, despite these liberal views of donation, popular rhetoric surrounding the commodification of organ and gamete donation is most often constructed as necessarily bad (see Baylis 2018a, Spar 2006).

Equating commodification with moral wrongness and gift exchange with altruism can be traced to the history of the gift/market dichotomy where, for example, Mauss (1966 [1925]) idealized the exchange of gifts as reciprocal relationships between persons and Marx (1978 [1887]) critiqued market exchange as removing the relationships between individuals through a process of alienation. In other words, gift exchanges are often assumed to maintain or create *social relationships* while commodity exchanges are understood as one-time exchanges that remove the individual from the relationship (Bell 1991). Hence, the rhetoric of gift exchange is often used to describe the donation of bodily goods because of the assumption that altruistic motives pervade gift exchanges while egotistical/individualistic motivations infuse commodity exchange (Schwartz 1967, Sherry 1983, Strathern 1984). These traditional arguments surrounding gift exchange generally fail to understand the culture which creates the commodity or the gift, instead focusing solely on the things that are exchanged rather than the "forms or functions of the exchange" (Appadurai 2013 [1983]:3).

Building off of Appadurai (2013 [1983]) and Zelizer (1979)'s work that attempts to understand the cultural process of exchange, sociologists and anthropologists have begun to note the rhetorical attempts that organizations take to remove bodily goods from the market, equating their exchange with altruism (Almeling 2011, Healy 2006, Hovav 2019, Ragoné 1999, Tober 2001). For example, organizations dealing in blood donation have constructed donation in terms of good citizenry, rendering payment unnecessary (Healy 2006), while egg donation agencies have cloaked the compensation provided to donors as altruistic "gift giving" (Almeling 2011). Hovav (2019) notes how the language of maternal altruism has become especially important in global exchanges of surrogacy as this rhetoric helps to rectify the tension between moral goodness (i.e., moral palatability) and commercialism. These strategies attempt to change the rhetorical atmosphere of the market so that the transaction becomes unnoticed and morally palatable (Healy 2006, Hovav 2019). For example, although egg donors in the United States may in fact be "egg sellers," as they routinely receive compensation for their eggs, the rhetoric of "gift giving", which necessitates a reciprocal exchange (Mauss 1966 [1925]), becomes a justification for the payment the donors are given *in exchange* for their "gift" of eggs (Schwartz 1967). In aligning egg donation with "gift exchange", egg donation agencies have attempted to remove eggs from the "immoral" marketplace. This removal reflects the dichotomy between gifts and markets (Marx 1978 [1887], Mauss 1966 [1925]), where gifts are seen as incompatible with market exchanges.

The rhetoric of gift giving has been critiqued, especially in the case of egg donation and surrogacy, as it is said to obscure the reproductive labour (e.g., the time, energy, and pain) of the donor in favor of the language of altruism (Marre, Román and Guerra 2017). Thus, the language of gift giving, and even the language of donation, is seen to remove the work a woman does to produce the gametes (Cooper and Waldby 2014). In failing to acknowledge the labour of women, some feminists have argued that donors are alienated from their "products" (i.e., gametes) and are unable to request a fair "market price" for their eggs (Marre, Román and Guerra 2017). They have highlighted how often egg donation, like women's other "intimate labour[24]" (Boris and Parreñas 2010), has been devalued in favor of a naturalization discourse, which places it in the category of "uncommodifiable" (Cattapan 2016b). This categorization further dichotomizes the

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[24] The day-to-day paid or unpaid labour that is required for survival and often involves touch, closeness and personal care.

relationship between production and reproduction (Marx 1978 [1884]), making it easy to suggest that it is "natural" for women to want to altruistically give their gametes to another (Almeling 2011, Marre, Román and Guerra 2017, Ragoné 1999). Furthermore, the association of women and altruism follows gendered scripts of feminine "gift giving" whereby women's reproductive work is undervalued (Almeling 2011, Lewis 2019). While feminists have critiqued the failure to acknowledge the "clinical labour" (Cooper and Waldby 2014) involved in producing gametes, the rhetoric of altruism ultimately helps to appease the ethical concerns with the commodification of bodily goods (see also Cattapan 2016b).

In this chapter, I explore the consequences of legislating altruistic donation through the criminalization of paid egg donation. I identify the processes by which eggs are given, bought, and sold within and outside of Canada. In examining these processes, I argue that the prohibition on the "trade in" eggs (*Assisted Human Reproduction Act* 2012) (*AHRA* 2004) does not actually prevent the commodification of eggs, and that the focus on this prevention as an "ethical good" is misplaced. Instead, I highlight the benefits of treating eggs as commodities as it allows for the recognition of women's labour and regulation over the ways eggs are produced instead of the outcome (i.e., the purchasing) of eggs.

OBLIGATORY GIFTING

The *AHRA*, which criminalized the payment for eggs, intended to prohibit the trade in eggs. Instead it idealized and valorized a gift relationship between an intended parent and a donor and effectively created a grey market for egg donation. In this grey market, either the donor would gift a woman an egg, or intended parents would use national borders (i.e., traveling abroad, importing frozen eggs) or illegal payments to exit the gift exchange. In this chapter, I complicate the *AHRA*'s idealization of the altruistic gift as ethically preferable to market exchange, showing some of the hidden assumptions of the gift relationship. I also explore the consequences of legislating altruism by exploring the exchanges that happen outside of Canadian borders.

In Mauss's (1966[1925]) seminal study of gift exchange, he suggests that a gift is much more than the object itself, but rather helps to create a social relationship between the giver and the receiver. In a society that is dependent on gift exchange, "gifts are rendered, received and repaid [is] both obligatory and in one's interest" (Mauss 1966 [1925]:27). In some ways the *AHRA* propagated the idea that eggs should be treated as gifts by prohibiting payment for an egg. However, the inability to be given anything in return for the egg(s) complicated the idea of the gift relationship as the intended parent was not allowed to give anything in return for the "gift of life" (*Assisted Human Reproduction Act* 2012: s7.2-7.4). Indeed, despite this prohibition, counselors reported on the ways that intended parents found ways to give to their donor by buying her an "air conditioner" (counselor 17) or through buying them a "bigger Christmas present" (counselor 05).

While recipients presumably saw this gift-in-return as completing the gift relationship, counselors felt that these gifts could complicate the relationships between donor and recipient even further by creating a sense of obligation between the giver and the receiver. A counselor described how a purely altruistic donation could create a sense of obligation between the intended parent and the donor—

> this sense of obligation down the road and compensation does happen in little ways it's, it's the bigger Christmas present, it's this do you want to go on a trip with us [the intended parents] (counselor 07).

Thus, the reciprocal relationship that this counselor describes reflects the type of relationships that result from traditional gift exchanges in which the recipient (i.e., the intended parent) is obligated to give something in return (Bourdieu 1977, Mauss 1966 [1925]). Since the gift exchange often does not occur immediately after an egg is given, the recipients' reciprocal gift may also be viewed as continuing the gift relationship such that the donor may then feel as if she may also have to give something in return. Thus, as a fertility counselor explains, the gifts that are exchanged may create a sense of continued obligation between the donor and the intended parent:

> So, imagine that you're the egg donor and you've done this [donated an egg]. Just as a gift. It is a gift, it is a gesture, you don't want anything else said about it. Once it is done. It is done. And I'm happy to do this for you and then your sister who has received this gift buys you something wonderful, lovely. Okay that's nice and then Christmas time rolls around and she buys you a large gift and maybe you're [the donor] not financially in a space to reciprocate (counselor 03).

As with many gift exchanges (see Malinowski 1920 for a discussion of the kula gift exchange), the giving of the gift does not end the obligation of exchange, but instead necessitates a continued exchange relationship between the giver and the receiver. Instead of ending the social relationship between the donor and the intended parent, the exchange of gifts further intertwines the recipient and the donor in a never-ending gift exchange (see also Berend 2016 for a discussion of gift exchange in surrogacy).

THE ALTERED SOCIAL RELATIONSHIP

Gift exchanges not only create a sense of obligation for the recipient to give-in-return but also create a social relationship between those who are exchanging (Bourdieu 1977). While recipients who know their donors generally have an existing relationship (i.e., a sister or friend), the act of donating one's genetic material to create a child may complicate that existing social relationship as the donor becomes both a sister/friend and a biological mother to the child born through egg donation. Some of the counselors in my sample saw a pre-existing relationship between donor and recipient as problematic. A fertility counselor explains how she felt that "coercion" could continue to occur in altruistic exchanges, especially when the donor and the recipient are related:

> This assumption that what is exploitative is the commercing [*sic*] and that the altruism makes it non-exploitative. To me actually is the opposite cause if you know that without your help, your brother or your sister or mother or aunt will never have a baby; to me there is actually nothing more exploitative than that . . . (counselor 02).

Here, this counselor points out an often-overlooked aspect of the relationship is that one's autonomy in decision making can be compromised by things other than money. Feminist bioethicists have long argued, contrary to conventional philosophical precepts, that "autonomy" in medical decision-making is not simply a matter of an individual enacting their wishes. Rather, they say that all notions of "autonomy" are necessarily created within social relations and is in fact dependent on the relationships that are formed in making a decision. Thus, the context in which the decision is made influences the ability to make a fully-informed decision (i.e., giving informed consent) (Donchin 1995, MacKenzie and Stoljar 2000, Sherwin 2008).

Although feminist works in bioethics do not explicitly address how previous familial relationships may affect a person's willingness to become an altruistic donor, they all recognize how relationships can affect people's willingness or unwillingness to consent to a procedure. Feminist approaches to consent argue that the power (im)balance within relationships must be understood in order to determine if "true" informed consent has been given (Ells 2003). That is, they critique the idea that altruistic exchanges are inherently self-regulating and necessarily morally good. Thus, in the case of egg donation, family relationships and the power which exists inside of these relationships, should, a counselor, explains be considered when evaluating the relationship between a donor and a recipient:

> Have you been comfortable in the past, disagreeing with your sister? And have you been able to say no?...You know she [the recipient] has been the big sister, she has always given me lots of money for my schooling. I feel like I owe her (counselor 14).

While many counselors in my sample felt like it was part of their job to ensure that everyone is “on board” and the “wellness of the relationship is maintained” (counselor 07), there is no national policy that ensures that the consent that occurs between the donor and the recipient is truly altruistic. Instead the law, through only restricting the payment of a donor, assumes that coercion could only happen in cases where money is exchanged. The lack of recognition of the way that past relationship dynamics might unduly influence a woman to donate may be a result of the construction of altruistic gift giving as ethical.

Not only does known egg donation rely on an assumption that the motives of the donor are purely altruistic and independent of power dynamics that may exist within a relationship, but it also ignores the complications that can ensue if and when a child is born. Like other types of gift relationships, the process of giving an egg creates a relationship between the donor and the recipient that may alter their previous relationship. This counselor continued to explain how she ensured that a non-coercive relationship would exist between the recipient and the donor even after a child was born:

> I really talk to them [the recipient and the donor] a lot about that because I don’t want them to have any coercion on either side. I also ask the intended parents, if there is a pregnancy how do you see the donor’s relationship? Is she a special aunt or is she a donor? I ask how is that information going to be disclosed to the other people around you, your child, extended family and friends and what have you decided in terms of disclosure and is it consistent with the donor and sometimes they have not talked about that and donors make assumptions and sometimes intended parents make assumptions that are not consistent [with the donor’s] (counselor 14).

Like the other counselors in my sample, she attempts to ensure that everyone knows what the potential child will be told about how they were conceived, and that everyone is okay with the situation. Another counselor explains the importance of the social relationship being defined from the beginning, “but the idea is that from the beginning you guys are deciding what these relationships are and that’s how you present it to the kids” (counselor 02). Thus, the conversations that recipients and known donors have with their counselors helps to anticipate the type of relationship that should exist after the “gift” of the egg is given.

Recipients who choose known donors not only had to navigate the gift relationship established between them and their known donor, but also had to navigate their continuing social relationship in light of the genetic connection between the donor and the future child. Fae, a recipient, understood that by asking her sister to donate, a different type of relationship would be created between them:

> It is a little bit different when you’re not a family member like when you’re a friend or a stranger, because when you’re a family member a lot of different things come into play because you can’t just go and give your eggs and never see that person again like . . . she is going to see her, the child she helped create, and likely it will look like my sister [more] than me but thankfully we both look the same, so it won’t be such a big difference.

The social relationship that Fae and her sister would have to negotiate is a result of the gift of genetic material to create a child. Unlike other material gifts where the relationship that is created through the gift exchange can be easily broken by failing to participate in subsequent gift exchanges, a family member or friend’s gift of a donor egg to another is more challenging as the “gift of life” will often result in a child that looks like the giver.

Fae and the two other women in my sample who used a known donor understood that their relationships may change because of the genetic connection between their possible child and their friend/sister. In contrast, some of the women in my sample specifically did not want to use a known donor because of the new type of social relationship that would form between them.

Jacky, a recipient in my sample, described how she did not want to use a known donor because if your children were "running down the street together it would seem like it wasn't really yours." She decided to travel to the Czech Republic because "having someone halfway across the globe" where there wouldn't be any claims to "biological parenthood" seemed more comfortable to her than using someone who could have "potential contact with offspring" (Jacky).

Counselors' work of ensuring purely altruistic relationships has begun to be recognized by the Canadian Fertility and Andrology Society (CFAS) (Havelock et al. 2016). CFAS best practices recommend that counselors be consulted to ensure a continued (altruistic) relationship between known donors and recipients. However, national policy did not mandate these counseling sessions nor did every clinic in Canada. When the clinics in my sample required counseling sessions, the ability to stop the donation process because of an ill-intended donor or recipient was often limited because of the timing of these sessions and the lack of professional authority that counselors held over the donation process (see chapter 4). Furthermore, recipients were often required to pay out-of-pocket for counseling sessions adding an additional expense to the already costly procedure. Thus, although counselors serve an important role in navigating potential donor relationships, counseling is not legally mandated, further reinforcing the assumption that known egg donation is essentially altruistic, unproblematic, and without power dynamics.

THE GIFT CONTRACT

Unlike gifts that are given for birthdays and holidays, these gift relationships often require contractual mandates. Fertility clinics in Canada are increasingly requiring that in the case of a known-donor relationship a signed contract should delineate the relationship between the recipient and the donor. A fertility lawyer explained how the contract that she created between the egg donor and the recipient defined the obligations of the donor and recipient:

> It is the weighting of obligations. The financial obligations that the egg donor may have had because remember the egg donor is the biological mother. The genetic mother of this child so by law she could have obligations of child support or she could have rights to information or access…. So, she is waiving all of that and in return…. the intended parents are absolving her of any responsibilities (lawyer 02).

The perceived need for a contract was due in large part because of the way that the exchange would challenge existing definitions of motherhood in that the biological mother, the donor, would not be the social mother of the potential child. Because of the saliency of biological motherhood as the standard form of motherhood (Franklin 2013b, Strathern 1992), many of the clinics that I spoke to require this contract. The *AHRA* did not mandate this contract as a requirement nor was it guaranteed that the contracts created would hold up in court. Instead as I argue in chapter 4, these contracts allowed clinics to remove themselves from any legal culpability in case of an "under-the-table payment." In addition, these legal contracts have become a standardized way to negotiate the social (rather than biological) relationship that will ensue once the "gift"' of the egg is given.

The idea of a contract to establish a relationship between a giver and a recipient contrasts with the idealized version of the gift in which a social contract between the recipient and the giver is assumed based on social context. By using a legal contract to establish the relationship between a giver and a recipient, the donor-recipient relationship more closely resembles a market exchange where the relationship established is predefined not by the egg itself, but a signed contract that is negotiated to define the relationship and the types of payments that will result once the exchange has taken place.[25]

These contracts are partially an attempt to *protect* the social relationship between the donor and the recipient; however, they also represent the difficulty in seeing an exchange of an egg between two known persons as a freely-given gift. While this lawyer explains that the contracts attempt to delineate the "receipted expenses" so that donors "can't make money off doing this," she also acknowledges that giving this "gift" can carry additional expenses. The contract, thus, not only describes the social relationship between the recipient and the intended parent, but it also describes the measures given so that donors don't "walk away from this in a financially worse off [way] than they started." In suggesting that egg donation should not be thought of as "charity", she implies that it is the eggs, not the time or the travel expenses that should be thought of as the "gift" to the intended parents (lawyer 02). The idea that the egg itself should be the gift rather than the process of egg donation contrasts with the more traditional gift relationship that Mauss (1966 [1925]) described. In more traditional gift exchanges, the gift encompasses both the item itself and the process by which that item was procured, and the recipient does not necessarily pay for the time and energy that went into obtaining the gift.
In my sample, what was considered as part of the "process" of egg donation was highly contested, and the way that reimbursable expenses were defined varied greatly.[26] Phoebe, a

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[25] For an example of how gifts generally do not entail a contract, imagine giving a dress to someone and having them sign a paper indicating when and how the dress could be used.

[26] When I was collecting my data, there were no guidelines surrounding the compensation of egg donors. As I am writing this chapter, there is a draft of proposed regulation that would regulate what expenses could be paid for and how those expenses could be documented (see Philpott 2016); however, at the time of writing this regulation had not been approved.

recipient who was using a Canadian agency to find a non-anonymous donor, discussed the way that the agency determined the expenses:

> so how it works is that I have given them five thousand dollars to put into an escrow account. Once the donation happens, she has to give them an itemized thing of expenses, which then they reimburse her from my escrow account and if there is any money left over, it comes back to me. The issue is that their itemization does not require her [the donor] to provide receipts. So, they can be for basically, the three weeks that she is in this process because between stimming, retrieving and recovery it's three weeks, there could be, she could write down that she spent a thousand dollars on groceries and then they will just pay her.

Here, Phoebe discusses how she paid $5,000 for the process of donating an egg; however, it was unclear if that process actually cost $5,000 or if the expenses that were being paid were just being hidden behind the language of gift. Almeling (2007) suggests that egg agencies in the United States encourage recipients to provide extra gifts to donors and use language of altruism to hide the market exchange that is clearly taking place. Although the market is supposed to be absent from the exchanges that are taking place in Canada, the gift rhetoric used serves a similar purpose: to (attempt to) remove egg donation from the market in favor of a more "altruistic" gift exchange.

In some cases, expenses were outlined in a formal contract while "gifts" were expected and established through an informal agreement between the donor and the recipient. This informal agreement outlined how much the recipient should be expected to "give-in-return" for the egg. Abigail described how this expectation of a gift-in-return made it financially unrealistic and legally dangerous to use a donor in Canada,

> I think that the main issue was that they [potential donors] all seemed to want money, they all seemed to want money under the table, and I don't want to break the law. Not only that, but I don't really have an extra 25 grand to pay for their medications and their IVF cycle and my own monitoring and also give them a spare eight thousand dollars plus their expenses.

While sometimes the extra sum of money that donors were receiving could be constructed as a gift-in-return for their efforts, Abigail, like most of the recipients in my sample saw through this rhetoric of gift exchange, seeing the extra eight thousand dollars as a payment for eggs.

Although this payment for eggs was in contradiction to the law, the inability to compensate a donor beyond her expenses created a system of obligatory gift giving where recipients often felt obliged to give-in-return while egg donors came to expect this payment. The system of “gift” giving allowed for the obfuscation of the market-based exchange that was occurring “under the table” (Abigail). Thus, in the case of known egg donation in Canada, language of altruism was used to overlook the continued exchange of money between donors, recipients and Canadian egg donation agencies.

For some, the language of altruism also served to remove any ethical concerns from the exchange that was occurring as these exchanges were considered “legal”, “altruistic”, and therefore, moral. A manager at a Canadian egg donation agency, highlighted the differences he saw between the Canadian and US system:

> you hear in the newspaper and you see these shows where people are making hundreds of thousands of dollars. But to pay a donor hundreds of thousands of dollars to buy her eggs is so distasteful to me. And quite frankly these [Canadian] donors are so happy, and they get so much out of the experience more than money could ever give you. I would really hate to see it not be altruistic and to move to a compensated US model. I probably wouldn’t be interested in it anymore because you’re not helping people, you’re taking advantage in my opinion (egg bank 02).

For him, the move to a compensated system meant that donors would be able to “take advantage” of intended parents demanding a certain price be given in exchange for their eggs. Buried in his statement is the assumption that donors in Canada are not given extra money for their eggs, and conversely that the US market exchange model negates the ability for donors to truly "help" people. Thus, money, for this manager and for others who argued for an altruistic model of donation, represented the devaluation of women's altruistic gift of donation.

The assumption that a compensated model would create a free market exchange for eggs where eggs-in-demand could be bought and sold for large amounts of money creates a false dichotomy between a "gift" and "market" economy. It also ignores the ways that other countries have successfully created limits on the amount of money donors can receive (see chapter 2). The manager's assessment of the contrasting models reflects this false dichotomy, rooted in the dualism that exists between "gifts" and "commodities" where altruism is seen as incompatible with market exchange (Scheper-Hughes and Wacquant 2002). The dichotomy that has been constructed of gifts being morally and altruistically "good" and commodities being "evil" and necessarily alienating (Joseph 2005) results in an inability to recognize the multiple ways that eggs can be and are construed beyond the gift/commodity dichotomy.

INEQUALITIES IN GIFT EXCHANGE

Holding onto the idea that the altruistic exchange for eggs creates a fairer marketplace for recipients and donors ignores the inequalities that can exist within an altruistic system and the way that the market exchanges continue to exist despite the legislation. One way that inequalities persist in the altruistic exchange of eggs is through the ability of certain women and not others to be able to find donor eggs. Lori explains how a lack of a sister made it difficult for her to find a willing donor—

> Unfortunately, I didn't have any sisters-- that was the big thing for the fertility program. They were like 'oh no problem. Just bring in your sister and she can be your donor, and you're good to go.' Well, I don't have any of those. So that's not going to work.

Here the inequality arises from the availability of known altruistic donors. Since it is easier to find an altruistic donor inside one's circle of friends or family members, those without large social networks may be less able to find a willing and able donor[27]. However, unlike a market exchange of eggs where inequalities may be remedied by financially supporting those who cannot easily enter the market (e.g., through insurance coverage, tax rebates), the inequalities that arise in an altruistic market are more challenging to fix as they rely on the generosity and availability of certain women inside of infertile women's social networks.

Andrea talked about the difficulties of finding an eligible donor from their group of friends and the discomfort of asking a woman outside of their social network,

> We didn't have anybody to ask. We did actually go through the "what about. . ." and "how about. . .", and let's just stand at the grocery store and ask people on the way out, and I wasn't comfortable with that. I also wasn't comfortable making a Facebook page or Facebook post that said, hey do you know anybody that has some spare eggs? Just not the kind of thing that we really wanted to do.

Most of the women in my sample (14/18; 78%) were in a similar situation as Andrea and did not have anyone to ask and were uncomfortable recruiting a known donor by themselves. Even for women who had a sister, cousin, or friend that they could ask to give them an egg, recipients were often concerned that the gift could change their relationship and offer a reduced chance of conceiving if their known donor did not fall within the recommended age range (18-32; 18-32; Havelock et al. (2016). Naomi explains why she didn't use a known donor,

> I had a friend offer and one of my sisters offered so you know that would have been like an altruistic donor but um I didn't [accept their offer] …. my sister is in her early forties and my friend in her late thirties, so it was like not great options if we were going to take a risk of doing something like that . . .. I actually didn't want [to] in the end; I wanted more distance like with, um, I wanted a donor that I liked but I didn't want to sort of have the complication of having a child who you know then it's like there is more complicated extended family dynamics (Naomi).

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[27] The "Guidelines for Third Party Reproduction" (2016) suggest that donors be given a medical history and screened for infectious and genetic diseases. While there are no existing regulations that require screening, most clinics require donors to be free from infectious disease and identified if they are "at risk" of donating gametes with genetic disease. Legally, all donors must be above the age of eighteen. There is no legal upper limit, but generally the limit is under 32.

Naomi decided to travel to use an egg bank in the United States both because she didn't want to complicate the existing social relationship between her sister and her friend, and also because in using one of these individuals who were older than donors in a donor egg bank, Naomi also lowered her chances of success.[28] So while Mac's assumption that altruistic egg donation is "fairer" because it does not cost as much to find an egg, an altruistic system does not remove all barriers to egg donation as women become reliant on their social networks to "gift" them an egg. This reliance may then place a burden on the women within that network to donate for their friend or sister as they realize the difficulties of finding another donor.

Furthermore, some of the recipients that I spoke with questioned the assumption that the altruistic system of donation is cheaper. Sam, a recipient who used a Canadian agency to find a known donor, talked about the expenses that she incurred in using a donor,

> She [the donor] was told to document everything [all expenses] and then they [the agency] actually sent us more bills on top of that [the capped expense of $5,500]. Even though, they sort of had the donor embellish things to make up the $5,600. And when we asked them for like a copy of the donor's expenses, we never got it. Even though it said it right in the stuff [the contract] that they [the agency] would send it [the documented expenses] to us.

The expenses that she paid the donor were supposed to be based on "how far she was from the clinic"; however, Sam did not know the number of kilometers the donor was from the clinic and "she [the donor] ended up doing a lot of local monitoring; so, she didn't even go to the clinic that often" (Sam). Thus, the expenses that the donor occurred for traveling seemed to be "embellished" in order to ensure that she received the full amount of compensation that had been set aside for her "expenses." In addition, Sam felt obligated to give her donor an extra gift at the

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[28] Egg donors who under thirty-five are more likely to donate eggs that result in a live birth (Wang et al., 2011).

time of retrieval. These embellished expenses allowed for egg donors to receive payment, labeled as a “gift”, allowing the agencies to uphold the rhetoric of altruism.

The amount the recipients “compensated” the donor was not the only cost that they incurred. In addition, recipients paid the legal fees for the donor as well as multiple counseling sessions[29], medication, and the cost of retrieval. These expenses added up especially if donors backed-out of the donation at the last minute, leaving recipients to start the process again with another donor. For Sam, it took seven donors before a donor agreed and Sam ended up with eggs that her fertility clinic could fertilize with her partner’s sperm. At the time of the first interview, Sam estimated that she had spent $35,000, and noted that “you can go to some of the other clinics in the Czech Republic and spend a third of that and get a vacation in.” The cost savings for recipients that were sometimes cited as a reason for criminalizing paid donation and recipients may not fully realized this savings. Instead, the expenses of going through multiple donors, paying for counselors, lawyers and agencies, compensating the donor and covering the costs of the transfer often added up to more than the cost of traveling abroad or importing frozen eggs.

Although the *AHRA* is often cited for making donation cheaper and more accessible for intended parents (Baylis 2018b), the “cost-savings” measures of an altruistic exchange were often not fully realized as the costs associated with altruistic cycles still tended to be high and were limited to those who could find a known donor. Thus, although altruistic exchanges were supposed to make egg donation more affordable the social (i.e., social network of friends) and

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[29] Sometimes recipients reported that their counseling sessions were covered by their insurance. However, unless the counselor billed the donor’s session as a session for the recipient, the donor’s session would have to be paid out-of-pocket. The amount that individuals paid for counseling was dependent on their insurance status.

economic capital needed to secure an altruistic donor often meant that egg donation was still reserved for the privileged (see recipient sample characteristics Appendix C).

PAYING FOR EGGS

The lack of knowledge surrounding how much a known donor cycle would ultimately cost was contrasted with the fixed price of using imported egg from the United States. Recipients who used imported eggs were given choices upfront regarding the price they would pay. The price varied based on the number of eggs that a recipient wished to purchase and the type of "insurance" plan that the recipients choose to opt into. For example, one frozen egg bank website reported that the cost of five to eight eggs with a blastocyst guarantee was $14,770 USD (~$19,500 CAD) plus the cost of the transfer (~$12,000 CAD). Some donor banks also offered a pregnancy guarantee after a certain number of failed cycles for an extra cost. These plans ensured that the recipient knew the full costs before engaging in a cycle, meaning that the donor could not request any additional fees and the clinic did not charge any hidden fees.

The explicit costs of importing frozen eggs were coupled with language that also explicitly recognized the purchasing of eggs. Rhonda described how she purchased a specific number of eggs from an agency:

> The lady from the egg bank called me and said, "how bad do you want these eggs? Because we are willing to give you eleven eggs for the price of nine." And I made a split minute decision, but I decided that that was a pretty good deal and I decided to buy the eleven eggs for the price of nine.

Rhonda's experience obtaining eggs relied on a bartering process where the supplier had extra eggs and was willing to sell them to Rhonda for a reduced price. Here, the market language is explicit in that eggs are given a certain price and money is exchanged for those eggs. Unlike the gift relationship that occurred when individuals used a known donor, the market exchange separated the donor from the recipient so that the no social relationship existed between the intended parent and the donor.

While this market exchange is precisely the type of exchange that the Canadian *AHRA* attempts to prohibit, it is seen as a preferable option to many recipients as it allows them to acknowledge the amount of effort and time that the donor spends donating her eggs.

> It is compensation for the person's effort and you know for doing the medication…. I felt good about the fact that she was being compensated for her effort and that she was being acknowledged and it seemed just more. . . I know that it is a really contentious issue here in Canada around sort of "paying for eggs" but it actually, I felt really good about it (Martha, frozen eggs)

Reports of "feeling good" about paying for eggs came from recipients who saw the effort that went into the donation process as something that was worth "paying for" (Martha). Although the recipients and the donors would not have a direct social relationship in that their respective identities were unknown to each other, the recognition of the donor's labour could be said to humanize the process even with the exchange of money. While the *AHRA* equates payment as coercing donors into donating, some of the women in my sample see the payment that they were giving to the donors (albeit indirectly through payments to clinics) as compensating them for their work.

Cooper and Waldby (2014:8) argue that bioethical rhetoric that dismisses the ability to pay a donor for their "clinical labour" is a result of "atavistic (yet fully functional) forms of labour contractor and desultory forms of compensation" that often ironically remove the protections of labour law in favor of compensatory practices. In refusing to pay a donor for her labour, the markets that arise are often informal and enlist women who are often part of a globalized precarious and devalued labour force (Hovav 2019). While the characteristics of donors in Canada are largely unknown, the travel for donors outside of Canada and the importation of donor's eggs from other countries plays into the global marketplace for egg donors. In this global marketplace, the dearth in supply could mean that, depending on a donor's economic position, she could demand high prices for her eggs (e.g., Ivy-league donors in the United States) or be given a set payment that allows for low-skilled workers to participate in the labour market (Cooper and Waldby 2014). Outsourcing Canadian's reproductive labour to other countries where women may not have the same educational, labour, or even health care opportunities creates a global market for reproductive goods where Canadians cannot fully regulate the process of donation, including but not limited to minimizing the donor's exposure to risks.

Counselors, lawyers and intended parents were also conflicted in their views of whether or not a gift exchange was necessarily morally preferable to a market exchange. A fertility lawyer remarked,

> I think we have a problem that we equate payment with exploitation. There are a lot of other ways that someone can be exploited. So, for example, so sometimes a donation between sisters can be really problematic…. There are sometimes when maybe one sister is being pushed by the parents, like, 'how could you not donate to your sister? This is the only way that she is going to have a baby that is close to our genetics.'…. None of this is easy. (lawyer 03).

This lawyer's concern about the ability to coerce altruistic donors runs contrary to the gift/market divide where altruism and gift giving is often uncritically determined to be ethically (and in this case legally) good. However, Curtis (2010:81) has noted how a language of altruism in egg donation can mean that egg donors overlook their own needs in favor of being "good givers." Not only does this result in women not being paid for their reproductive labour, but it also may result in them overlooking the risks of egg donation in favor of helping create families "out of the goodness of their hearts".

The recipients who saw eggs as both a commodity and a gift, sometimes purchasing them from a United States' frozen egg bank, openly acknowledged the money the donor was receiving as a payment. Phoebe discussed how we needed to stop "fooling ourselves" stating,

> I am buying eggs; it is a commodity. It is the same way that I come into work every day and my employer buys my ability to research, analyze, my knowledge, and my willingness to, you know, to be vocal and lay down the law with individuals. There are all kinds of ways of supporting yourself and for some people that is going to include donating eggs. Like I don't know what is going to happen with the money that I give her. She is a student, probably it is going to be living expenses, and books and tuition, you know. But I think we need to stop fooling ourselves and saying that people are 'donating' eggs because they're not.

This view of donation saw the reproductive labour involved in donating and explicitly discussed the payment as money exchanged rather than a gift exchanged. Unlike other work on gamete donation and surrogacy where intended parents seem reluctant to talk about the payment the donors or surrogates may receive (see Hovav 2019 for an example), the recipients in my sample were often frustrated that they could not explicitly discuss the amount of money a donor was receiving.

Meredith explained her perceptions of the motivations of the donors were, "I'm not going into this with rainbows and puppy dogs, like I know why they're donating. They're donating for the money and that is fine." Similarly, Rhonda talked about how she "loved her [donor's] honesty. She [the donor] said, 'honestly I'm doing this for money for my children, so I can do things for my children'…. and I love that about her." Thus, many of the intended parents who used frozen egg donors were not opposed to paying an egg donor as they often saw this work as labour. Martha, an intended parent, described the labour the donor performed: "the day where she has to go to the clinic for whatever tests, she is missing work and um you know her gas and her lunch." Here Martha, talks about the donor taking time off of work in order to perform "clinical labour" or the (unrecognized, risky) labour that gamete donors perform (Cooper and Waldby 2014).

Thus, Martha and others considered it "reasonable" to pay the donor as long as it was a "reasonable amount." However, much like other commodities which are created overseas, the consumers (i.e., the intended parents) are unaware of how much the labourers made (i.e., the donor). Instead, they only know the final cost of the eggs that they paid to the egg bank (~$14,500 CAD). Thus, part of the result of the *AHRA*, which intended to prohibit the commodification of gametes, created a market in which consumers desire to pay women for their work as egg donors but do not know how much payment she is receiving for that work. Thus, the *AHRA* effectively set up a system where donors are being paid under the table in Canada (also see Hammond 2015) or abroad, but those who purchase the eggs are often unaware of the conditions in which egg donors are providing their eggs, or how much money a donor is receiving.

DISCUSSION

Altruism and gift giving are often constructed as "morally palatable" exchanges (Hovav 2019), in which the lack of or minimal exchange of money removes the ethical barriers of donation. However, this chapter elucidates how framing egg donation as a purely altruistic exchange leads to moral consequences including who has access to an egg donor, how social relationships are affected between the donor and recipient through the exchange, and how the egg donor's reproductive labour is understood and recognized. Although the *AHRA* constructs payment for eggs as morally and legally incompatible with "Canadian values" (Baylis 2018a), I argue that the inability to recognize women's reproductive labour further entrenches the gift/commodity divide (i.e., “hostile worlds” approach (Zelizer 2005)) and ignores the ethical issues that arise inside of the market exchange for eggs inside of Canada.

Feminists scholars have long pointed to how the “hostile worlds” approach, present in discussions surrounding the exchange of bodily fluids (e.g., breast milk), body parts (e.g., egg donation) and wombs (e.g., surrogacy), has further removed women’s labour from ethical discussions in favor of language that encourages women to be “altruistic givers” (Almeling 2011, Anleu 1992, Curtis 2010, Fourcade and Healy 2007, Hovav 2019, Nelson and England 2002, Smith 2015). While there may be concern that in favoring a market exchange of eggs some women may be unduly influenced to donate, money is not the only thing that can influence a women’s decision (Bayefsky, DeCherney and Berkman 2016). In this chapter, I have shown how the power imbalances that currently exist within known donor relationships may unduly influence a woman to donate even if she is not given money. These power imbalances also may exist or develop over the course of the donation process, especially if a child born resembles the donor. Thus, the assumption that a truly altruistic donation does not carry moral or ethical challenges ignores the material realities of the donation process and the relationships between donors and the recipients.

Counseling sessions can be used to address the effect of egg donation on social relationships, ensuring that a power imbalance does not affect the decision of the donor to donate. Conceivably these counseling sessions might also examine the motivations of the donor, ensuring that the donor considers the relevant risks of donation in light of the money that she will be receiving. However, a dualistic view of altruistic donation as necessarily good and market exchange as necessarily bad has largely prohibited these discussions surrounding undue influence resulting from existing social relationships and/or money exchange. Furthermore, the lack of knowledge about how much money an egg donor within or outside of Canada receives from donation makes it even more difficult to regulate compensation so that undue influence cannot occur.

The other ethical concern— that the commodification of eggs through market exchange would change the relationships between people—is also a fallacy because of the way that egg donation (and especially altruistic egg donation), in absence of money, already does alter relationships between recipients and donors. For example, recipients often feel obliged to give in return. In addition, if a recipient decides to use a family member or friend, the recipient, donor, and future child may have to continually renegotiate their relationship because of new familial and genetic connections. The use of contracts to solidify these altered social relationships highlights the inability for an altruistic system to prevent these changing social relationships. The gift/commodity divide present in Canada's legislation, thus, ignores the influence of past and future power dynamics in influencing a donor, hides reimbursable expenses behind the language of gift, assumes that any money that is given for eggs will create a free market, and ignores the clinical labour that donors perform in providing their eggs. That is, in seeing egg donation as a gift exchange, the process (i.e., work) of egg donation is ignored in favor of altruistic language. Furthermore, this divide is contrary to how many of my participants explained the eggs they received. They saw the clinical labour that the donor was enduring and wanted to compensate her for her work, *and* the way that this work she was performing would be a "gift" to them. Thus, they wanted to give her something in return. I argue that egg donation cannot solely be thought of as an altruistic gift given by one donor to a recipient as this ignores the ways that the market exchange is still at play in many of these exchanges and the ethical concerns that arise when donor's reproductive labour is not fully recognized. In viewing egg donation as a market exchange, women’s reproductive work in donating eggs can both be recognized and regulated to ensure that she is neither unduly influenced to donate nor unfairly paid for her work.

The next chapter explores the global market of egg donation. I empirically travel to the Czech Republic and Spain to see how these fertility markets, partially propped up by the ability to compensate egg donors, are able to successfully recruit Canadian patients who are unable to find an altruistic egg donor in Canada.

Chapter 6

“Most of the people that work here know the culture”: Mobilizing Cultural Health Capital in overseas fertility clinics

“So most of the people that work here, they know the culture, they speak the language of [the patients], which means that they adapt to the patient that is calling” (fertility coordinator, SP clinic 36)

As noted in Chapter 2, the restrictions that the *Assisted Human Reproduction Act* placed on egg donation made it challenging for some women in need of donor eggs to find an egg donor in Canada. This challenge may help to explain why, in a survey of Canadian fertility tourists, Hughes and DeJean (2010) found that the number one reason that Canadian women travel for fertility care is for egg donation. The travel for egg donation is not unique to Canadians as intended parents who lack access to fertility care in their own country often travel to countries with more liberal legislation (Hudson et al. 2011, Inhorn and Patrizio 2012, Rosée Gomez and de La Rochebrochard 2013). Cross border reproductive care represents a market response to the lack of available treatment in some countries (Connolly 2011); however, the ability to travel from one country to another is in large part due to the travelers’ socioeconomic background: white, wealthy Western women are more likely to pursue egg donation in other countries because they have the economic, social and cultural resources to navigate foreign systems of care (Martin 2009, Russell 2015, Whittaker and Speier 2010).

Although CBRC may have democratized fertility services, providing cheaper options in foreign countries, Franklin (2011) suggests that CBRC does not serve to unilaterally increase access to reproductive care. Instead, Franklin argues for an institutional examination of the practices of CBRC to show how certain organizational structures make it easier for some people to gain access to reproductive technologies abroad. While the biopolitical structures that allow for certain markets to arise in countries with liberal legislation[30] have previously been examined (see chapter 2 and Hudson et al. 2011, Martin 2009), little is known about the ways in which fertility clinics attract fertility patients within these liberal marketplaces and how these strategies may serve to create marketplaces for particular types of fertility patients.

Starting with two popular sites of reproductive travel, the Czech Republic and Spain, I analyze how fertility clinic professionals in eighteen different clinics rely on knowledge of their perspective client's cultural expectations of medicine and fertility care. In doing so, I argue that fertility professionals in clinics in the Czech Republic and Spain draw upon cultural health capital (CHC), knowledge of specific attitudes and behaviors surrounding medical treatment and care (Shim 2010). Clinics target certain types of fertility patients, namely white, upper-middle class North American and Western European patients, who can readily identify with the type of care these international clinics are providing. The reliance on these specific strategies to make particular clients comfortable may serve to reinforce stratified reproduction as particular clients are deemed worthy of targeted reproductive care.

In applying CHC to fertility travel involving fertility clinics located outside of North America (i.e., the Czech Republic and Spain), my research specifically highlights the ways that fertility professionals in their interactions with foreign clients must manage language and cultural differences while signaling their clinic's efficacy and safety to be perceived as a suitable clinic for patient travel[31]. By examining how actors at fertility clinics embody and institutionalize

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[30] In addition, the presence of liberal legislation does not mean that countries will automatically become sites of care. Places like Argentina and Ukraine also have liberal laws but do not attract as many fertility travelers.

[31] Since my interviews were with the English-speaking coordinators, I focus on how these individuals engage cultural strategies of English-speaking patients. Many of the clinics that I attended had different fertility coordinators who spoke different languages and also managed the cultural expectations of these patients.

CHC, I highlight the importance of CHC in patient-provider interactions that happen across borders. I also show how successful implementation of CHC can be used to further increase the success of the fertility clinics in a global marketplace while simultaneously further contributing to the stratification of reproductive care. While CHC is often used to conceptualize how existing social inequalities are reproduced on the level of the patient (see Dubbin, Chang and Shim 2013, Gengler 2014), I broaden its application to examine how markets are created, illustrating how creating markets for certain patients may serve to further "stratify reproduction" (Cohen 1995). Cultural and economic resources of the travelers stratifies reproductive care as only those who can afford to travel and have the knowledge to navigate the global marketplace are able to interact in this marketplace, catered to their specific needs.

THEORETICAL BACKGROUND: PERSPECTIVES ON CULTURAL HEALTH CAPITAL AND CROSS BORDER REPRODUCTIVE CARE

Shim (2010:1) describes cultural health capital (CHC) as the "repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles, cultivated by patients and clinicians alike, that when deployed may result in more optimal health care relationships." Shim's concept builds from Bourdieu's (1986) idea of cultural capital, where a person's accumulation of resources and practices such as their style of dress, verbal skills, and scientific knowledge functionally defines their place in the "field". The "field", according to Bourdieu (1986) is the distinctive set of norms and rules in a particular setting that consists of and reflects the social structures and power relations within a society. The "field" that medical professionals and patients interact within is the health-care system where scientific knowledge and authority of the medical profession (usually represented by physicians) have high status.

Patients, according to Shim (2010), gain access to and acceptance into these medical fields more or less successfully depending on their level of CHC.

Generally, research surrounding CHC examines how patients exert their cultural health capital such as knowledge, insurance status and socioeconomic characteristics to access quality health care (Abel 2008, Gengler 2014, Shim 2010). This research shows that persons with greater resources have more CHC and thus receive better health care, oftentimes gaining more knowledge and resources in the process. CHC has helped to describe how micro-level interactions such as provider-patient conversation are products of macro-level inequalities and how these micro-level relationships serve to reinforce greater structural inequalities (Dubbin, Chang and Shim 2013, Madden 2018, Shim 2010). However, little research has been done on how CHC can be used to generate successful health care markets that in turn favor patients with high CHC.

Shim (2010) originally conceptualized cultural health capital (CHC) as a comprehensive framework to understand the macro- and micro-level encounters that shape health care interactions. This concept has been used mainly to explain patient-provider interactions in US contexts (Gengler 2014, McConnell 2017). When these interactions are analyzed, they are usually interpreted based on how the provider reacts or responds to the patient's CHC (i.e., presentation of self, insurance status, health care knowledge) (Dubbin, Chang and Shim 2013, Epstein et al. 2005, Madden 2018), rather than showing how health care providers themselves must also mobilize their own cultural health resources to respond to their patients' needs. Overlooking health care providers' use of CHC may be due to the assumption that all providers carry similar CHC in that they occupy a distinct socioeconomic space (i.e., well-educated, earning above the median income, having a prestigious profession) in North American society.

However, as patients travel abroad for medical care, the assumptions of CHC are challenged as medical professionals must signal their CHC to patients who occupy a specific stratum of society (i.e., well-educated, upper middle-class) to attract patients to their clinics (see Appendix C). This signaling may be particularly necessary in global reproductive health care markets where nations are hierarchically ordered with some destinations being more or less desirable to largely white, Western privileged reproductive tourists (Whittaker and Speier 2010). In this context, health care professionals, who are largely assumed to be higher status in Western contexts, are not necessarily perceived this way by reproductive travelers.

Economic and cultural resources in medical tourism

The economic resources that fertility patients mobilize to gain access to fertility treatment both abroad and at home have been well-documented with white, educated, Western, high-earning individuals having better access to fertility care (Bell 2010, Greil et al. 2011b, Whittaker and Speier 2010). This stratification is only heightened in the case of Canadian egg donation as Canadian provincial health services do not generally cover this treatment. Thus, not unlike in the US, infertility is part of a privatized medical market where consumers are (partly) responsible for driving the institutional mechanisms (Conrad and Leiter 2004). The consumption of infertility services is only heightened in the case of abroad treatment as the province does not cover these services.[32] Thus, fertility travel like other forms of medical travel requires the economic means to access services.

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[32] In some provinces, it is debatable whether fertility patients can claim the medications purchased in Canada for an overseas cycle, or the travel itself, on their taxes. Even if a patient was to claim these expenses, most of the cost would be paid-for by the patient as the majority of the expenses are not for the medications.

The access to fertility services is not only a product of who can pay for services, but also who is expected to be infertile. That is, due to cultural expectations of who is a good mother, those who fit into the model of the white middle-class family are more likely to have the medical community recognize their experiences of fertility, and thus, are also more likely to seek treatment (Bell 2010, Thompson 2005). This research suggests that white upper-middle class women have both the economic capital (i.e., money to pay for treatment) and cultural health capital (i.e., characteristics of those who are considered infertile) to gain access to treatment. In Speier's (2016) study on North American's travel to the Czech Republic for egg donation, her respondents were mainly white, had a university-level education and were middle to upper middle class.[33] My sample of Canadian patients who traveled to the Czech Republic and Spain mirrors Speier's sample (see Appendix C) in that all but one of the patients who had traveled earned over the Canadian median household income (>$80,000 CAD).

While people with greater CHC may be more likely to travel for reproductive care, other macro-level and institutional factors may influence patients' decisions. In chapter 2, I highlight how the biopolitics surrounding egg donation make it more difficult to access egg donation in Canada. There are also other factors such as decreased costs and waiting times (Speier 2016, vanhoof, Provoost and Pennings 2013, vanhoof and Pennings 2015, Whittaker and Speier 2010) as well as trust in the receiving clinic that may influence patients' willingness to travel (Dalstrom 2013, Guy, Henson and Dotson 2015, Speier 2015). While trust in the care received has been highlighted as an influential factor in making decisions surrounding fertility travel, little is

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[33] While white, middle-class, well-educated patients may be more likely to travel, there is no statistical evidence of how many of these individuals who need reproductive care travel.

known about how medical clinics signal to potential patients that their clinic is trustworthy (Deomampo 2019, Martin 2018).

In addition, the life-encompassing aspect of fertility treatment that Becker (2000) describes as a “quest for success” transforms fertility patients’ desire to get pregnant into a consumer rights movement entangled with purchasing the best available fertility care. Therefore, these international fertility clinics may use more personalized approaches to care such as patient-centered care precisely because they recognize that their services exist in a marketplace where their clients expect to receive care that is attentive to their medical needs and social desires to parent (Spar 2006). Martin (2015) suggests that US clinics market their services to international clients, not explicitly, but simply by having a “web presence.” This presence allows international patients to find US clinics. However, how clinics located in less reputable places for medical care, such as the Czech Republic and Spain, are able to convey to travelers that their website matches their services is largely unknown.

Race and egg donation

A major social desire of parenting is to parent a child with a biological connection (Thompson 2005). When those needs cannot be met because of infertility that requires the use of an egg donor (i.e., another’s genetic material), intended parents often look for an egg donor that is phenotypically similar to them to maintain an illusion of relatedness (Nahman 2013, Szkupinski Quiroga 2007, Thompson 2005). In order to facilitate this illusion, clinics often categorize gametes as “white,” and “non-white” based on existing racial categories (Nahman 2013). Although white intended parents’ desire for the use of gametes that are classified as “white” has been well documented (see Speier 2016), little is known about the process by which fertility clinics use the availability of white donors to construct their clinic as an international destination for fertility care.

Defining the cultural "tool kit"

This chapter explores the cultural health "tool kit" (Swidler 1986) that clinics use to gain clientele and enter into the global fertility market. Instead of focusing on how individual patients organize their behaviors to gain access to care, I focus on the "strategies in action" that clinics take to mobilize their CHC and then convert that CHC to gain status and profits in the global fertility market. I argue that clinics rely on a specific cultural toolkit that provides intended parents with the feeling that they are being treated at a clinic in North America. Clinics signal their CHC through their use of online technologies and networks, language tailored to the client, membership to international professional organizations, interactional styles, patient-coordinators, and bioracial discourses. In turn, reliance on these specific strategies-in-action, serve to create a cultural of care that is comfortable for the affluent white recipient, further entrenching the idea of who "should" be provided access to fertility care.

I first describe how fertility clinics relied on online advertising agencies to position themselves as recognized players in the global fertility market. I then show how clinics used their own websites written in English to suggest that English-speaking patients could find service at their clinic in a language they understood. Language was important not only in advertising their services, but also in providing care; all the clinics in my sample had at least one person who could communicate with the client in their native language. In addition to language, clinics marketed medical affiliations and evidence-based medicine (EBM) to suggest to their clients that they would receive the highest care possible. They also drew on language of patient centered care (PCC) to create a culture where their patients felt like they would be provided with individualized care. Finally, I show how bioracial discourses surrounding whiteness and family-making were mobilized differently in the Czech Republic and Spain, elucidating how clinics mobilized “white resources” to attract white fertility patients. These “strategies in action” created the feeling that their foreign clients would receive the same type of care they would receive in their home countries. Simultaneously, these “strategies in action” served to reinforce who *should* become a fertility patient and thus, a fertility traveler.

MAKING THE CLINIC SUITABLE: USING ONLINE TECHNOLOGIES TO CULTIVATE TRUST

To attract international clients to their clinics, clinics realized that they would have to specifically target the international market by branding their clinic as suitable for North American patient travel. A physician at a fertility clinic in Spain noted, “one of the main goals is to make the clinic closer to the patient and you have to do it with webpages or whatever. You must do it with new technologies. You can’t physically go” (physician, Spain, clinic 27). Speier (2011; 2016) describes how in the past clinics cultivated trust amongst international patients by hiring fertility brokers, persons (usually women) to find and attract clients to their respective clinics. She describes the process of an infertile Czech woman who lived in the United States setting up a business where she would act as the intermediary between potential patients in the US and a clinic in the Czech Republic. This model created a system of trust between the potential client and the fertility clinic as the intended parents were able to communicate directly (and often in-person) with someone who understood both the culture of the Czech Republic and the United States. The fertility broker was the “cultural guide” (Lareau 2015) who explained to patients the high quality of treatment they could expect to receive in the Czech Republic, and who made the travel arrangements for the fertility clinics.

Although Lareau (2015) conceptualizes a cultural guide as a person inside of a one's existing social network, I argue that medical facilitators serve as cultural guides because they helped the potential client navigate a different type of health care institution, bridging the cultural gap between the fertility traveler and the clinic. While these cultural guides, who served as both translators and patient navigators, may have decreased language barriers between the clinic and the recipient, they also come at a high economic cost to the clinic and potential traveler as the medical service facilitators charge a fee for their services.

In addition to the limiting the profits of the clinic, fertility brokers also posed a problem as not every clinic had an individual broker located in every potential recruiting country. Even the few clinics that used fertility brokers as methods of recruiting their patients were restricted by where their broker was located. Thus, fertility clinics started looking for new ways to expand their market by directly targeting their patients through the internet. The head of a fertility clinic explained, "you come to some website. Most will build-up some feature page. So that's why you pay them to have a feature page of you, and about the hospital and territory that you'll see and then they are sending you inquiries that are coming through their website" (Czech Republic clinic 23). Instead of relying on a person to bring individuals to their clinic, they cultivated an online presence by using website agencies, fertility forums, advertisements and their own websites.

Online agencies were places that listed available clinic locations and allowed for intended parents to contact numerous potential fertility clinics through a centralized website. A patient coordinator at a fertility clinic in Spain described how their fertility clinic used webpages and networks to recruit clients:

> There are a few different websites that we are listed on. One is called *Visit and Care,* visitandcare.com. If a patient, well they don’t recommend a patient, but if the patient finds them on their website and the patient uses the website then we pay them a percentage or a commission of that treatment. There is another website that we actually pay yearly to be advertised on their website. And there are a few websites that are free to advertise. And they don’t charge a commission and they also don’t charge us to advertise so we advertise that way [sic] (patient coordinator, Spain, clinic 35)

The online agencies that this patient coordinator describes were not responsible for communicating directly with the intended parents, but rather served as a portal by which intended parents could connect with a variety of clinics. While some of these websites charged an advertising fee or recruitment charge, the expense of advertising on these websites was much less than paying an individual person for their services. These portals became an inexpensive way that fertility clinics could expand their patient networks to anyone who searched for egg donation online.

Online agencies served as a localized place where intended parents could compare various clinics’ costs and treatment options. The fertility travelers I interviewed saw it as a convenient way that clients could do their homework before deciding to travel. Some of these fertility travelers told the story of just looking for treatment options in Canada or the United States before stumbling upon these portals that directed them to clinics located in the Czech Republic and Spain. Macie describes how her and her partner “started looking at going to the States and we started googling egg donors online and found some places online…so I started researching those clinics directly.” Since the contact was free and could be done from the comforts of their own home, fertility travelers saw this contact as having nothing to lose. Fertility clinics’ use of the internet to target potential patients may be due to a larger cultural shift where patients have become more comfortable planning trips and shopping for items online.

For instance, while the travel agency used to be the site of vacation planning, today these agencies have often disappeared.

Macie, a fertility traveler, talked about how she and her partner decided not to use a medical broker for her travel:

> We just did it on our own. I looked at the agency and then yeah. I figured like we had traveled to Europe a couple of times. And so yeah, I just contacted the clinic myself and started talking to them and I thought I don't really need somebody to go between. A lot of their services were like we will find a hotel for you and things like that. And I was like, well I can book a hotel. And everybody at the clinic like spoke perfect English and so I didn't think we needed to pay for that.

Macie and her partner's comfort in traveling to a clinic that advertised through an online agency rather than a person reflects a broader do-it-yourself trend in vacation booking where website agencies like Expedia and Orbitz have come to be recognized as the cheap and efficient way to book travel (Ku and Fan 2009). While potentially allowing for more potential travelers to find their fertility site, the ability to navigate multiple websites including fertility clinics, hotels and travel also relies on the ability to navigate healthcare information online, eHealth literacy, whereby consumers have the requisite knowledge to distinguish good information from bad. Individuals with higher socioeconomic capital are both more likely to have higher media literacy (Kontos et al. 2014), potentially narrowing the type of traveler to one that can book their fertility service online.

Social network sites like IVF.ca and Facebook provided another source of information surrounding fertility clinics' reputations. Andrea stated that the first thing she did when she found out she needed an egg donor was to "join a forum/board. I think it is called Fertilityfriends.uk" Although the board was made-up of "predominately UK" women, she used the website to "to find out what information there was on IVF abroad information." Fertility traveler Jacky said that she often used these online discussion groups to find “logistical information” like if there were any “language barriers” and to get a sense of “what the clinic was like.” Since these groups were already a place that fertility patients went to look for support and information (Kahlor and Mackert 2009, Slauson-Blevins, McQuillan and Greil 2013), they provided fertility clinics a direct way to reach their potential clients.

Unlike online website agencies where fertility clinics could pay to advertise their services, fertility clinics were unable to directly advertise on these social networking sites due to site restrictions that limited interactions to fertility patients. Instead, clinics relied on past fertility patients to create informal social networks by discussing their clinics on these webpages (Hanefeld et al. 2015). When asked how patients found out about their clinic, the marketing director of a clinic in the Czech Republic stated:

> Also, you know word of mouth because that’s just how it works. If some people have a baby from us, they’re going to spread the word. And so, we get that a lot that. They’ve heard from somebody. And also, online all those forums that. They just discuss everything. These ladies are online, and they discuss everything. And they also discuss options (clinic 25).

Fertility clinics, thus, realized how social networks provided a free way in which their own past patients acted as a “cultural guide” to other potential patients. McConnell (2017) describes how members of a similar social network (e.g., members of the same fertility forum) are more likely to gain positive instrumental support (e.g., treatment suggestions) from cultural guides who had positive health care experiences. For international fertility clinics, recruitment through word-of-mouth was instrumental in finding new clients:

> And I feel especially for medical treatment, medical business the best way is. A lot of people from Italy, for example, are coming because somebody returned and said we were there [at the fertility clinic in the Czech Republic]. And they have a really nice fertility clinic…A lot of people are coming because they heard from a friend sometimes much

> more than advertisement on the part of the clinic. So, it's really great for us to have good reviews of course (medical director, CZ, clinic 22).

Many fertility clinics operated in this same manner creating connections with patients from one country to expand their client-base. This idea that specific fertility clinics became a site for international patients of a particular nationality provides support for a social networking hypothesis in that fertility patients gained information on the types of treatment that were available abroad through their own infertility communities. Sophia spoke about how her connection with another woman who had previously traveled to the Czech Republic for egg donation made it seem less scary—

> I had actually never met this couple before. The wife and I sat down, and we talked it through quite a bit. And she is probably one of the most skeptical people that you'll meet. She works for the RCMP [Royal Canadian Mountain Police], but that's just engrained in her. And she was quite open and forthcoming with a lot of the information and her own experiences. I think that that helped me mentally going into it, that this isn't going to be as scary as it is. But I think having being [*sic*] able to talk to people that have experienced it and gone through the process made it a bit easier to go through the process ourselves.

The stories that patients told on these forums and to each other in person became a way that clinics cultivated an image among abroad clients. That is, they relied on past fertility patients (that spoke the same language and had the same cultural knowledge) to become "cultural guides" for future patients. In relying on their clients' social networks, fertility clinics could also ensure that they were tapping into networks of people who had the economic resources to travel. That is, since individuals within the same social network are likely to share the same economic resources (Lin 1999), in using word-of-mouth, clinics were able to build a client base that could afford egg donation in their clinics.

USING LANGUAGE TO BRAND THE CLINIC

These online and in-person social networks that created “cultural guides” for future patients were necessary as the “cultural guide” in the form of the fertility broker disappeared. However, having past clients speak about the service they received was not enough. Clinics also had to cultivate their online image so that potential clients, who were highly educated consumers used to researching their health options online, could find information about their fertility treatment options (Kahlor and Mackert 2009). Although online fertility travel agencies helped to display the location and types of treatment the clinics offered, these agency websites only represented the first contact that potential clients had with clinics. The fertility travelers I spoke with frequently talked about the research that they did:

> And so, we went back researching what our options would be which would be overseas. So, I researched a few different countries and a number of different clinics and made a spreadsheet to compare the data and what was included and what wasn’t (Andrea).

Andrea’s ability to make a spreadsheet of available clinics was contingent on her own health literacy as well as clinics’ displays of information. Thus, clinics also had to actively signal their ability to treat international clients through designing websites that were suitable for international patients. This included creating multilingual websites to attract clients who spoke various languages and displaying their clinics’ certifications and success statistics in a way that complimented the personal testimonials present on fertility forums. Most websites were specifically curated for the English-speaking patient, meaning that these websites were carefully designed and translated so that they were created for the English-speaking traveler. In speaking about how the clinic used its own website to attract potential clients, the marketing director of a fertility in clinic stated, “I put everything on the website in English. So that was a big thing” (marketing director, SP, clinic 22). Having everything in English on the website signaled to potential clients that the clinic was an appropriate destination for their fertility travel.

Clinics recognized the utility of their websites for engaging international patients and used their websites to brand their clinic as a suitable and safe place for egg donation. A marketing director at a fertility clinic in Spain explained her role, “I’m trying to you know of course bring patients here but also our main thing is the name of the clinic” (clinic 25). The “name” that this marketing director was referring to was not only the actual name of the clinic, but how the clinic wanted to brand itself on the international market. Some clinics that I spoke with talked about how their clinic was known for their innovative research: “I don’t know if you’ve seen something on our website, but we are studying the effects of music in the beginning of the life. So, this is very unique…because it is innovation” (marketing director, SP, clinic 32). Another clinic used brochures to brand itself as a clinic that was engaged with the latest technology— “when science and technology meet, the best results are born” (brochure, SP clinic 35). Another emphasized its history: "we are the first IVF center in the Czech Republic” (physician, clinic 23, CZ). In doing so, clinics signaled to their international clients that their specific clinic could offer them something different than other international clinics, and similar or better care they would receive at home.

In this way international clinics used medical discourse that their clients were familiar with to create a niche market. Their websites and brochures used language such as “pioneer,” “leaders,” and “experts” to engage a type of traveler who wanted to get the best care possible (clinic 25, 27, 28). Instead of comparing their clinics to other clinics in their country who were also doing research, clinics who engaged in this strategy often positioned their research in the global field— “professional experts with high international prestige, pioneers in research” (website, SP, clinic 27). This use of discourse signaled to potential clients like Abigail who knew of the "negative stereotypes of Eastern Europe" that the clinic was able to provide her with trustworthy and advanced medical care. Thus, clinics asked their patients to see their clinic as competing with the care that they would get in their home country rather than the care that they expected to receive abroad.

Sara described how the clinics' use of the latest technologies helped her to make the decision to travel to a specific clinic in the Czech Republic:

> The technology was becoming more popular the um. Now I don't even remember what it was called. It's when you take the picture of the egg and the embryo about every 20 minutes and they can really see when the cells are dividing, and they can assess which embryos are the most likely to result in a positive pregnancy so this embryoscope, that's what I think it is.

While the reason that Sara traveled to the Czech Republic in the first place was to find an egg donor, the technologies of the specific clinic that she chose helped her to pick that specific clinic. The ability for the clinics to differentiate themselves in the international market, thus, became about how the clinic used and advertised technology to attract potential clients who wanted to receive the most advanced treatment possible, "we did feel that it would be advantageous to have that technology used in this procedure" (Sara). The use of advanced technologies was one tool that clinics used to engage their CHC, showing potential clients they would be treated with the best technologies.

Those who strive for successful fertility treatments with the newest and latest technologies can be seen to be "good mothers" (Thompson 2005). Thus, Sara like others in my sample, wanted to attend a clinic who used advanced technologies like the embryoscope, a technology that allows for the close monitoring of the developing embryo. Visual reproductive technologies such as the embryoscope allow for fertility travelers to engage with their treatment, often times suggesting that this intensive engagement by both the fertility clinic and the traveler will create success (Franklin 2013a). Lie (2012) argues that the visualization techniques such as an embryoscope have become increasingly important in IVF as they allow for the creation of life to become public, effectively showing the "advanced" technological effort the clinic engages in to make a baby. In doing so, technology becomes equated with "the best" despite evidence of the success (or lack thereof) of newer more visualizing technologies (Joyce 2008). Clinics use these visualizing technologies to signal their ability to meet their clients' desires to engage with the best possible technology, and to distinguish themselves from other clinics who may not be engaging with the same technology. By advertising their use of the newest technologies, clinics become "good clinics" who could compete on the international market for fertility travelers. They also help clinics tap into narratives of anxious reproduction whereby the woman is supposed to expend all energies to have a child (Faircloth and Gürtin 2018). These cultural messages of anxious reproduction and intensive motherhood are often targeted at affluent white women because they have the economic capital to pursue these strategies, further defining for whom these technologies are suitable.

Technology was not the only important factor in signaling that clinics could help their clients achieve pregnancy as success rates provided evidence at the clinics' ability to serve their international clients. They used their web presence as well as brochures to broadcast their success rates— "our 90% average success rate" (brochure, SP, clinic 29). These clinics did not expect their international clients to take their personal claims of success but also participated in "audits by the Spanish Fertility Society (SEF)" and frequently published their results so that their "patients [were] clearly informed on the effectiveness of the treatments they are to undergo" (clinic 29). A physician at a clinic in Spain explained, "And so we have nothing to hide in terms of results and pregnancy rates. We are completely transparent. And I think that is something that the patients really appreciate.” Publishing success rates that were audited and higher than other clinics also served another purpose—to advertise to patients that their clinics were safe, trustworthy and effective.

Other clinics went so far as guaranteeing that their clients would become pregnant after three cycles or they would get their money back:

> In that [egg donation] program what we say is after three egg donations, almost 100% of the patients get pregnant so if we are certain characteristics to be accomplished, in normal patients, in standard patients, and they go through 3 cycles and are not pregnant, we give the money back. And they don’t have to pay for the cycles in advance and that is another thing that is appreciated because it means that you trust your own program (physician, Spain, clinic 27).

Here, the physician talks about creating trust in the treatment by offering a money-back guarantee to certain patients and by allowing patients to pay for their cycles after the procedure rather than before. Fertility clinics’ websites displayed externally verified success rates and promoted their guaranteed treatment plans to suggest that they were part of larger system of health care, which patients could trust.

SIGNALING SAFETY THROUGH PROFESSIONAL MEMBERSHIPS

Despite the perception that individuals engaging in medical tourism may travel to countries where dangerous procedures take place (Snyder 2013), the fertility travelers I interviewed used safety standards to distinguish which clinics they deemed suitable. Andrea explained how she choose her clinic from an online list:

> There were four clinics that I kind of narrowed it down to and I made my spreadsheet of all their factors, how long they’d been in business, what their success rates are, what their multiple pregnancy rates are to determine you know are they kind of in-line with Canadian standards cause there is a clinic, you can go to in Cyprus and…..they will routinely transfer four day five blastocysts made with young donor eggs…..they will routinely do that if you are a foreigner.

In Andrea's spreadsheet, multiple pregnancy rates became a cultural symbol by which Andrea rated the clinics' attentiveness to current medical standards and practices. While not all fertility travelers may care about the multiple pregnancy rates of a clinic, every fertility traveler attempted to verify the international clinic's legitimacy. Just as in the United States, where clinicians expect that their patients respect scientific medicine and their professional recommendations (Shim 2010), Canadian patients expected that their clinics would respect the professional standards set-out by professional fertility organizations.

Another way that clinics signaled to potential clients was through membership in one or more of the major fertility organizations (e.g., the European Society for Human Reproduction and Embryology, the American Society of Reproductive Medicine). These professional organizations have recommended standards of care that go beyond the standards set-up by the country's laws where the clinic was located (e.g., number of embryos to transfer). The countries' laws were not only important for taking care of the potential client, since fertility travelers were also increasingly concerned with how the donor was being treated. A physician at a fertility clinic in the Czech Republic explained to me which standards they used in deciding how to treat donors,

> there's really where we cooperate with the American Society for Human Reproduction; for STD [testing], cryopreservation, and cystic fibrosis [screening], of course. And we have a special condition that we only accept donors with at least one baby. And there is only one other clinic who uses this condition (physician, CZ, clinic 20).

By using high standards to treat their donors, this clinic signaled to potential clients that the clinic was willing to follow safety guidelines that fertility travelers recognized.

In allying themselves with these professional organizations' standards, clinics suggested to their potential clients that their standards were similar to (if not better than) other international clinics. Timmermans and Berg (2003) suggest that standardization through clinical guidelines (such as guidelines surrounding donor-testing) has become increasingly common as medicine moves towards an evidence-driven practice, evidence-based medicine (EBM), rather than clinical experience. They argue that EBM has the potential to allow for various actors to gain legitimacy as guidelines are based on published scientific studies. For clinics in the Czech Republic and Spain, their allegiance to EBM, allowed them to partake in the global market of fertility, precisely because they could use the same (universal) guidelines as a reputable Canadian or American clinic.

In complying with international standards that their potential clients recognized, fertility clinics played by the "rules of the game" (Lareau 2015). While Lareau (2015) uses the concept "rules of the game" to acknowledge how white middle-class young adults mobilized informal and formal cultural knowledge of educational systems to succeed, I extend her concept to address how institutions can use the "rules of the game" to claim membership to an established field. In this case, fertility clinics used the "rules of the game" previously established by North American fertility clinics to signal to (mainly white) middle-class individuals that their clinic was "safe", and thus like other established clinics.

Playing by the "rules of the game," included clinics' attentiveness to evidence-based guidelines. Sara described how her "comfort level" in a clinic in Mexico diminished after she contacted the clinic;

> I was engaging the doctor and asking about donors. You know, my comfort level about how to know that it would be the right donor for me kind of thing. Because it [egg donation] is anonymous there [in Cancun] as well. I think at this point. I don't remember exactly the words, but it sounded like the doctor was saying we could probably show you a picture or something like that and I think it was like a picture or something of what the person looked like at the time….And as much as a customer, I would love to see a picture of the donor that they were going to be proposing to me when it was something that was

> against like I think it was government policy or whatever, I felt uncomfortable that then the doctor would suggest that they would break the rule.

The idea that the "doctor would break the rule" concerned her as then she became "concerned about what other rule might be getting broken" (Sara). In this case, the clinic in Mexico failed to abide by the "rules of the game" and in doing so failed to convince this fertility traveler that clinic and the destination was "safe." Since other clinics were available that abided by "the rules of the game," fertility travelers like Sara were able to differentiate between clinics that abided by the standards and those that did not. Ultimately, Sara choose to travel to a clinic in the Czech Republic who used its compliance with professional guidelines and national laws to signal the safety of the clinic. The failure by the fertility clinic in Cancun was due to this clinic's misinterpretation of what rules were supposed to be followed. These cultural signs are important to Canadian patients as the Canadian and US healthcare fields have taught patients to value compliance with professional recommendations and rules (Shim 2010).

INTERACTIONAL STYLES AS RULES OF THE GAME—PATIENT CENTERED CARE (PCC)

Although evidenced based medicine is often contrasted with patient centered care (PCC) as it privileges the biological over the patient-experience (Miles and Mezzich 2011), fertility clinics who targeted international clients navigated both systems of medicine. This navigation may be due to the increasing pressure for medical professionals to be attuned to patient's biopsychosocial needs to provide quality care (Mead and Bower 2000). Patient centered care is also a part of the increase in the consumer-orientation of the medical care where patients have become clients who choose treatments and doctors (Conrad 2005, Conrad and Leiter 2004); thus, Canadian patients, especially patients with high socioeconomic status, have come to expect that medicine be tailored to their individual needs.

Since fertility travelers were engaged in choosing international fertility clinics from a long list of options, clinics attempted to advertise their attentiveness to the individual patient. They did this by providing an "individual diagnosis and treatment plan" so that their clients were "not just a number" (brochure Spain, clinic 35). One way that clinics provided PCC was through individualized treatment plans where they took a "different approach with every patient. So, everything is tailored to what they [the patients] need" (patient coordinator, Spain, clinic 35). This tailoring of treatment helped fertility travelers feel as if they were "receiv[ing] total care. I [Sara] felt like they were very customer service oriented" (Sara). This customer-service orientation helped to target Canadian fertility travelers who often expected individualized service because of their high socioeconomic status (economic capital) and fertility-patient status (cultural capital).

Fertility clinics who did not respond to the patient's individualized needs were often excluded as potential site of travel. Josey explains:

> The clinics in Spain also just seemed not as responsive. Like I remember trying to hound them for information and I thought the heck with it, if I have to hound you for information and I'm paying you a ton of money for your service. I don't think that's the way it should go.

Josey's desire for attentive service maps onto ideas surrounding a customer service approach to health care and health care delivery where to exist in the global marketplace of health care, clinics not only had to have a lab that was technologically advanced and offered the highest success rates, but also had to work to build relationships with their clients.

One way that clinics built relationships with their clients was by using patient coordinators. Patient coordinators are individuals, mainly women, within the fertility clinic who help guide the fertility traveler through treatment. They were also in charge of the "emotional work" or the types of work required to emphatically serve clients (Hochschild 1983). By being with the "patients from the beginning to the end of their treatment" (physician, CZ, clinic 24), patient coordinators played an active role in recruiting the intended parents to the clinic and helping the client feel comfortable once they are there. A patient coordinator described his main job as "respond[ing] to client's emails. That's number one thing. The clients send emails in the evening from 6 pm to 10 pm so first thing in the morning, I respond to emails from previous day" (CZ, clinic 24). Thus, the patient coordinator assures that the client feels that the fertility clinics can meet their needs and feels an emotional bond with the coordinator herself. This role is unique to the abroad experience as Canadian clinics did not have a person to guide an intended parent through getting treatment at the clinic. The lack of a cultural guide at the Canadian clinics suggests that the fertility treatment is like any other medical service one would receive in Canada. Therefore, one does not need a guide to get to or navigate the clinic. In an abroad setting the patient coordinator served as a cultural guide, ensuring that the intended parents felt comfortable with the clinic and the country that they are visiting for travel.

One way in which patient coordinators made their potential clients feel comfortable was through having a patient coordinator available to speak to the patient in their native language. Andrea explained that she specifically chose a clinic that had doctors who were able to communicate fluently in English:

> We were assigned to an English-speaking coordinator with the different clinics and their English is pretty darn good. And most of the doctors spoke English too. There are some countries that you go to and you end up with somebody in the room with you who is translating back and forth between you and the doctor while the procedures are going on, but I think that the clinics that we picked, the doctors all spoke English.

While some of the fertility travelers in my sample choose clinics where not every member on their fertility team spoke English, every clinic in my sample had a patient coordinator who could speak English; thus, facilitating the patients' feelings of comfort with the clinic as the cultural gap of language was overcome.

Although speaking the language of the potential client was a required skill of the patient coordinator, the role of the patient coordinator was more than "just translating" (patient coordinator, Spain, clinic 35). A patient coordinator explains her emotional labour:

> making sure that they [the fertility traveler] are happy but that they're not going to go home with kind of sour taste in their mouth. And it also affects treatment and if they're happy with treatment then you have a higher chance of becoming pregnant because you're in a better mood and that can affect so (patient coordinator, Spain, clinic 35).

Here, the patient coordinator suggested that her role was also instrumental in impacting the success of the treatment as making the client feel "happy with treatment" was equated with a "higher chance of becoming pregnant" (patient coordinator, Spain, clinic 35). While stress and happiness are not linked with treatment success (Wilson and Kopitzke 2002), the idea that the patient coordinator could help the client navigate successful treatment by providing a client with care that made them happy, permeated the beliefs of the fertility clinics and the fertility travelers I interviewed. This emotional work (Hochschild 1983) of the patient coordinator is seen not only to affect the satisfaction of treatment but also the success.

The emotional work of the patient coordinator facilitated the travel of the patient to the clinic as it created an emotional connection between the traveler and the fertility clinic. Once this connection was established, fertility travel could be embarked upon with the mindset that the fertility traveler would relax, travel to a foreign country and receive high-quality treatment facilitated by a patient coordinator. The travel itself, however, was sometimes viewed as a barrier to treatment. A patient coordinator in the Czech Republic explained to me that she was often responsible for dispelling some "cliché information" about the Czech Republic's culture: "people say Prague is a center of beer and of cheap sex, so some people think… They think we are here for people who want to drink and so on. So, it's these types of questions" (clinic 20). Thus, in addition to communicating the treatment plan to the intended parents, the patient coordinator's role was to dispel cultural stereotypes and assert the quality of the care the client would receive.

This assertion of quality also included the suitability of the country as a destination country. Unlike in the US where clinics are expected to offer high quality care (Martin 2015), clinics in Spain and especially in the Czech Republic reported constantly having to prove that their clinic and the location was suitable for patient travel. The head of a fertility clinic in the Czech Republic explained how the questions the intended parents asked were often more about their stay in the Czech Republic rather than about their treatment:

> the first thing I think about is that they will see that we are university hospital and they will ask about the clinics and everything. But finally, they are asking about the food. They are asking more about accommodation and really often the questions about the treatment are often the second or third position which is really interesting because if you think you would like to treat something, my first opportunity would be what is the references of your center and normally those questions aren't the first (clinic 25).

Thus, questions that intended parents asked were often about the "the drinking water or I don't know if there are some buses" rather than the treatment itself (patient coordinator, CZ, clinic 20). Patient coordinators and other fertility clinic staff assumed that questions surrounding the suitability of the clinic arose because of fertility travelers' preconceptions of the Czech Republic based on its history. In talking to intended parents, patient coordinators asserted the suitability of the destination as well as made it clear that the treatment they would be receiving would be similar to (if not better than) the treatment they had received at home. These emails played an important role for intended parents in my sample, who were deciding between different countries as the emails helped to assert that the destination was "safe."

These cultural guides were often in charge of ensuring that not only the client perceived the clinic and destination as safe but also oversaw setting-up accommodation and transportation for the client:

> We have 24/7 service, so the patients come to Prague and they have all the services around, so somebody come to the airport, and so somebody for example will arrive at the airport and we [the clinic] can help them with the reservations or something. (physician, CZ, clinic 22)

The patient coordinator became the "cultural guide" that could assist fertility travelers with their travel by using their knowledge and resources of the destination city. While not all fertility travelers stayed in the hotels or used the transportation option that the clinic offered, the ability to offer such services suggested the clinic understood the stresses of travel and would provide appropriate assistance to fertility travelers. For those that were not as savvy travelers, the willingness for the patient coordinator to help with the travel of the patient removed the potential cultural barrier of traveling in a different country as the patient coordinators would choose hotels and transportation options that reflected a North American patient's expectations. In providing appropriate accommodation that was targeted to upper to middle-class individuals, fertility clinics signaled their ability to care for a particular type of patient.

MOBILIZING BIORACIAL DISCOURSES

The fertility travelers that I interviewed were all white (see Appendix C) and all were looking for an egg donor that was phenotypically similar to them—"I wanted them to choose someone as genetically close as possible" (Jacky). Sara explains how she did not travel to Mexico because she "wasn't sure what their, whether they would have a big pool of donors that would be Caucasian because it was important to me that the donor be similar in appearance to me." Thus, the perceived availability of donors who looked like the intended parent was important in choosing a destination. This desire for a phenotypically similar donor is not unique as previous studies have established the ways in which intended parents look for racially similar donors to create an illusion of biological relatedness (Nahman 2013, Speier 2016).

Fertility clinics in both the Czech Republic and Spain recognized this desire of a phenotypically similar donor and used bioracial discourses to suggest that intended parents desired these characteristics so that the relatedness of the clients' future family would not be called into question. A fertility coordinator at a Czech clinic explains:

> there are a lot of patients who don't talk about it with anybody so it's important for them that the kids look like them, like has the same features um because a lot of them are religious and so it's important to them that the kid looks similar to them, has the same features, the same color of hair and stuff like that (clinic 25).

Thus, clinics actively worked to "imagine everything [physical characteristics] of the patient" (physician, Spain, clinic 28) to provide a racially desirable donor.

While all the clinics reinforced the idea that a phenotypically similar donor should be used, they did so in different ways: in the Czech Republic intended parents trusted that the clinic would match their donor to their physical characteristics while in Spain, phenotypic-matching was mandated by law. A physician at a Czech clinic explained the requests that their clinic received from intended parents, "they're mainly physical of course because the majority, they would like to have to have blond hair, dark hair" (clinic 20). For clinics in the Czech Republic, these requests aligned with the availability of donors as these clinics, "don't have a lot of ethnicities uh but we don't have many like we don't have black or Asian donors" (director, CZ, clinic 19). Although many of the clinics in the Czech Republic were not able to match non-white intended parents with non-white donors, clinics used the availability of white donors to target white fertility patients. For example, when fertility clinics featured images of babies and mothers on their websites, they were largely white. Fertility clinics in the Czech Republic, thus, mobilized the demographics of their country to target a fertility population who had the same phenotypic characteristics. Abigail described how she felt comfortable traveling to the Czech Republic because of the availability of "white donors"; "so, I have really light skin and brown hair. Like straight brown hair and so we might get a better match for my look in Eastern Europe." In recognizing that mainly white patients were traveling to their country for care, fertility clinics relied upon cultural discourse of race and biology, which assume that these characteristics are solely inherently intertwined (Nahman 2013), to market their location as suitable for North American travel.

In Spain, law required this targeting, and therefore, institutionalized phenotypic matching (*Spanish Royal Decree 42/2010 of January Which Regulates the National Commission for Assisted Human Reproduction [Translated]* 2010). A physician explains, "So the matching for the Spanish law has to be done according to the physical characteristics" (physician, Spain, clinic 27). This law, although part of the larger biopolitical economy of the Spanish fertility industry (see chapter 2), created guidelines of practices so that intended parents could be ensured that their donor would look like them. These guidelines were more than just rules as fertility clinics in Spain relied on the regulations to advertise and guarantee their ability to match donors to recipients. These regulations became a kind of cultural health capital that Spanish fertility clinics can rely on as they ensure the donation does not result in the "disrupt[ion] of a family" (physician, Spain, clinic 29). Campbell (2007) argues that fertility clinics are implicated in this practice as they attempt to match patients and donors through clinical means. Fertility coordinators and physicians in Spain often describe how "biologists" did the matching, almost suggesting that the clinic genetically selected these phenotypic characteristics rather than relying on a more complex process of natural genetic selection and expression. In the case of mandated phenotypic matching, the adherence to the law and the suggestion that scientists choose the expressed genes of the donors creates a racialized discourse that ensures the “suitability of the donor” by upholding the idea that families should be phenotypically similar. It also creates an assurance on the part of the fertility traveler who desires a phenotypically similar donor as there is an external body that demands that the clinic provides a donor that looks (and thus is deemed) “related” to the fertility traveler.

Although all the clinics in my sample engaged in these bioracial discourses and practices to meet the demands of their patients, one fertility coordinator suggested that these practices were “ridiculous” and saw it as his job to inform clients that

> It [phenotypic matching of the donor] is not so important because everyone, each one of us has the genetic information from all of our ancestors. I think so if two people create a new life together, the child can have all characteristics from all ancestors from our history, I think. So, I don’t think it is particularly important if people choose donor with hair color and stuff like this. I think it is a bit nonsense from my point of view, so I leave it to the clients, some clients want to choose exactly what they want but some clients they don’t cause maybe they just want to match the blood type in the end (CZ, clinic 24)

Although this fertility coordinator ultimately left the desired characteristics up to the fertility traveler, this reimagining of bioracial discourses that sees genetics as going beyond skin, hair or eye color shows the potential for these technologies to disrupt current perceptions of race and relatedness (Franklin 2013b). However, despite these technologies’ potential most clinics stressed their ability to provide a donor that matched the client, continuing to draw on bioracial discourses that linked biology, race, inheritance and family creation.

The availability of “white donors” in the Czech Republic and Spain and the lack of available “non-white” donors meant that clinics often were unable to meet the demands of certain populations (e.g., in the Czech Republic a clinic reported that they did not have “Asian donors”). Thus, the phenotypic matching practices legislated in Spain and institutionalized in the Czech Republic coupled with the demographics of the donors in both countries served to reinforce the idea that white patients should and *could* be treated for infertility. These institutionalized practices of phenotypic matching further stratifies reproduction (Cohen 1995, Ginsburg and Rapp 1995) as the availability of non-white donors is limited, making it difficult to “treat” patients of color who “require” non-white donors. The availability of phenotypically “white” donors, thus, serves to reinforce that these clinics treat “white” patients.

CULTURAL TOOLKITS IN OVERSEAS CLINICS

International fertility clinics located in the Czech Republic and Spain cultivated their images as suitable destinations for patient travel by relying on cultural tool kits such as online technologies and networks, language, professional memberships, interactional styles, and bioracial discourses. While these strategies in action indicated to the potential traveler that the clinic was safe, trustworthy and offered the newest technologies, the patient coordinator in the form a “cultural guide” assisted the patient in becoming a fertility traveler. The fertility coordinator did this by assuring the fertility traveler that the clinic would meet both her fertility and travel needs. These cultural tools and cultural guides came together to represent that the clinic had the cultural health capital to care for a Canadian patient.

Although previous research has focused on fertility patients’ experiences traveling abroad (Inhorn and Shrivastav 2010, Inhorn, Shrivastav and Patrizio 2012, Pennings et al. 2009, Slepicková 2010, Speier 2016, Whittaker and Speier 2010), little research has examined the way that markets have arisen because of this travel (for an exception see Martin 2015). While arguably the major reason that these markets have developed is because of inconsistent fertility policies across nation states (Pennings 2002), little is known about how the clinics within these countries establish themselves as legitimate destinations for care. I argue that clinics who mobilize cultural health capital (e.g., English-based websites, fertility patient coordinators) become successful at attracting patients to their clinics. Unlike prior work on CHC, which mainly focuses on doctor/patient interaction, this article shows the ways that CHC is mobilized as a marketing strategy to attract particular (read: white, middle-class) clients. Clinics that do not abide by the "rules of the game" (Lareau 2015); thus, are often marked as illegitimate by fertility travelers.

By examining how health care systems at the global level engage in CHC to gain clientele, my research shows how CHC is not only something that individual patients use to better their health status, but also that businesses and organizations can mobilize to produce profits. While much of the CHC literature focuses on how patient populations without CHC fail to access the health care system (Missinne, Neels and Bracke 2014, Shim 2010), this research overlooks how global markets produce inequalities in health care by using particular cultural signals and resources to attract *specific* types of clients. In using the framework of cultural health capital (CHC) to better understand how medical professionals use cultural signs and symbols in fertility markets, I expand the concept of CHC to include how social networks of wealthy, well-educated, mainly white individuals are targeted and provided access to egg donation that fits their individual needs. The ways that these individuals are targeted may have implications for others who do not have access to online resources or the ability to travel, contributing to the further stratification of reproductive services and travel. That is, in creating clinics that are tailored to affluent white fertility travelers, clinics may reinforce the idea of who should have access to fertility services. Previous research has shown how these cultural expectations of who is a fertility patient have contributed to the stratification of reproduction as reproductive health care professionals are more likely to investigate white patients for fertility problems (Greil et al. 2011b), and poor women and women of color themselves are less likely to seek fertility services (Bell 2010). Clinics who use cultural health capital (CHC) to target white affluent patients uphold rather than challenge the ideal of the fertility patient even when these services come at a discounted price. Thus, in showing how fertility clinics use specific cultural toolkits aimed at white affluent patients, I challenge the idea that fertility travel allows for the democratization of fertility services, showing how reliance on specific strategies in action may serve to attract (and deem treatable) a particular type of reproductive traveler.

Chapter 7 Conclusion

As the number of individuals using donor eggs both in Canada and abroad continues to increase (ASRM 2017, Evans 2016), there continue to be ethical concerns surrounding the process of egg donation. These concerns mainly arise from objections to the potential commodification of human life, stemming from the "selling" of human eggs and the known and unknown physical risks that women who become donors undertake to give their eggs to another woman (Downie and Baylis 2013, Royal Commission on New Reproductive Technologies 1993). In Canada, the response to these ethical concerns was the *Assisted Human Reproduction Act (AHRA)* which criminalized payment for eggs. This act has received widespread criticism, both by individuals who feel as if the act has not gone far enough in protecting vulnerable women from the potential harms of donation (Baylis and Downie 2013, Downie and Baylis 2013) and by those who feel it further marginalizes infertile women unable to conceive with their own eggs (Cattapan 2013, Housefather and Cohen 2018).

Despite these longstanding controversies, there has been a lack of empirical research examining the processes by which Canadian women find and use donor eggs. What little work that has been done shows that despite its prohibition, eggs continue to be bought and sold on a "black market" (Hammond 2015, Motluck 2010). Previous research also suggests that Canadians who are unable to find eggs in Canada and/or are unwilling to engage in this black market travel across borders to find donor eggs (Hughes and DeJean 2010). Through in-depth interviews with Canadian recipients and Canadian and overseas medical professionals, I show how they have responded to the restrictions placed on egg donation and how the global market for eggs has influenced the practice and receipt of egg donation. This dissertation adds to prior research, detailing the processes by which Canadian women find eggs and the fertility care professionals' responses to the restrictions placed on their practices. I also show how overseas clinics become suitable sites of care for Canadian women.

I started out this research with the basic question: How do Canadian women find and recruit donors when there are restrictions on paying donors? I was also interested in how this restrictive legislation may affect the type of ART services that Canadian women received. From previous research on Canadian CBRC (Hughes and DeJean 2010), I expected to find Canadians traveling abroad for egg donation. I was interested in how women made decisions about traveling for egg donation and how Canadian fertility care professionals helped them make these decisions. I also wanted to explore how both Canadian fertility professionals and Canadian recipients felt about using eggs from women in different countries. By interviewing fertility care professionals in the Czech Republic and Spain, I hoped that I would be able to better understand how these clinics attracted Canadians and what standards of care they used to ensure their potential clients of the safety of their practices.

This concluding chapter describes and analyzes how the *AHRA* has influenced the practice of egg donation and the globalization of egg donation services. In my summary of key findings, I also explore the ethical and moral implications of these regulations and market processes. Next, I propose changes to the regulation of egg donation within Canada, keeping in mind the way that eggs are exchanged in a global market. Lastly, I conclude with some limitations of my work and directions for future research.

SUMMARY OF KEY FINDINGS

My research has several implications for the ways that bodily economies and the regulations of bodily economies are understood. Overall, this study explicates how regulations can affect the type of care individuals receive. Although the *AHRA* may not prevent the commercialization of egg donation, it does affect where and how Canadian women receive donor eggs. That is, without this legislation egg donation, may resemble something more like the system of the Czech Republic, where Canadian women pay Canadian fertility clinics and banks to find and recruit eggs donors who are compensated a set amount. The laws in the Czech Republic and Spain have successfully placed a limit on the amount an egg donor can receive while also allowing for the market to exist. This study of international fertility clinics, therefore, also sheds light on how regulations can also serve to limit market actions without necessarily curtailing them. While some may argue against the marketization of eggs because of the presumed moral superiority of altruistic (rather than market) exchanges (Andrews and Nelkin 2001, Baylis 2018a, Scheper-Hughes 2000), my research adds to the body of work that shows how altruistic exchanges can be also embedded within power relationships that challenge ethical values of consent and autonomy (Almeling 2011, Marre, Román and Guerra 2017, Miner 2017, Smith 2015, Zelizer 2000). From my research, three interrelated findings emerge:

1. Despite restrictions placed on Canadian medical practices, Canadian medical professionals were able to use their professional authority to maintain control over the egg donation process. I show how fertility clinicians conduct boundary-work to shift the legally and ethically contentious practices of egg donation, what I term the “dirty work” of donation, onto other fertility professionals.
2. Although the Canadian system attempted to restrict the commercialization and commodification of donor eggs, the commercialization and commodification of eggs continues to exist, partially due to the global market for donor eggs. I argue against the dualistic conception of gift/commodity exchange, showing how eggs can inhabit both types of exchanges.

3. In the global market for donor eggs, countries which have liberal legislation attract patients to their clinics through specific strategies in action that signal to their potential clients that they will receive high-tech and safe medical care. I expand the term cultural health capital (CHC) to show how specific cultural expectations of care can become institutionalized in the medical clinic. This institutionalization of care targeted towards white affluent patients may further stratify reproduction as the care is intended for and advertised to a specific type of infertility patient.

First, I examined how Canadian medical professionals responded to the *AHRA* in light of the threat that this act posed to their medical practice. I argued that Canadian medical professionals were successfully able to use their professional authority to transfer the ethical and legal work that the *AHRA* necessitated onto other fertility professionals, namely counselors and lawyers. This transfer relied on medical professionals' boundary-work (Gieryn 1983), the practice of defining non-medical or non-scientific activity (e.g., ethics) outside of the work of medical professionals. One consequence of boundary-work was that it left other fertility professionals to do the ethical and legal work of egg donation, what I call the "dirty work" (Hughes 1962). This work is deemed "dirty" because of the continued political debates in Canada of what is and what is not considered ethical altruistic donation (see Housefather and Cohen 2018) as well as the criminal consequences that can result if one does not abide by the law. In combining Hughes' (1962) concept of dirty work and Gieryn's (1983) concept of boundary-work, I strengthen knowledge of how medical professionals respond to legal and medical threats. The reliance on boundary-work shows the ability of the medical profession to use its professional authority to continue to navigate challenges to its profession and maintain control over medical processes.

Second, I extend current scholarship on egg donation, by demonstrating that even within an altruistic marketplace, eggs continue to be commodified. This work lies in contrast to prior scholarship which generally focuses on the broad philosophical question on whether eggs should be commodified (Baylis 2018b, Downie and Baylis 2013), yet neglects the empirical situation. To analyze my data, I drew upon previous sociological and anthropological theories of gifts (Douglas 2002, Lévi-Strauss 1987, Malinowski 1920, Mauss 1966 [1925], Scheper-Hughes and Wacquant 2002) and markets (Andrews and Nelkin 2001, Anteby 2010, Marx 1978 [1887]) to show how the gift(altruistic)/market(immoral) dichotomy fails to capture the ways that eggs can act as both gifts and commodities (Appadurai 2013 [1983], Fligstein and Dauter 2007, Fourcade and Healy 2007, Healy 2006, Hovav 2019, Zelizer 2000, Zelizer 1979). This "hostile worlds approach" (Zelizer 1979) that dualistically positions markets as necessarily amoral and gifts as inherently moral exchanges, fails to recognize how even within altruistic exchanges, coercion (or at least undue influence) can take place. In arguing for a more holistic view of the gift/commodity relationship, I suggest that eggs should be thought as both gifts and commodities that exist within social relationships of money and power. In recognizing these relationships, regulations can be made to ensure that these social relationships remain consensual and do not overly burden a specific group.

Finally, I travel empirically to the Czech Republic and Spain, the two most popular countries for egg donation in Europe. Here, the exchange for eggs is not limited but rather promoted by individual actors at fertility clinics who recruit international clients. These international clients, some of whom are from Canada, are often looking for an egg donor because of the restrictive laws in their home countries. However, the presence of lenient laws surrounding compensation and the availability of egg donors are not enough to make these sites obvious destinations for fertility travelers. In addition, clinic staff must engender trust among potential fertility travelers. Clinic staff does this by drawing on cultural health capital (CHC), the cultural skills and knowledge that create optimal health care relationships (Shim 2010).

Specifically, clinic staff use CHC to mitigate concerns surrounding the safety of the clinic and the effectiveness of care the fertility travelers may receive. They do this by relying upon language of “patient centered care”, registering with national and international recognized medical organizations, promoting the high-tech nature of their clinics, and relying on bioracial discourses to advertise the bioavailability of “white” donors. In doing so, clinic staff institutionalize CHC so that clinics become places that white, wealthy North Americans and Western Europeans will travel. This institutionalization of CHC has consequences for who is considered an ideal fertility traveler as clinics focus their attention on certain groups of women presumed to need medical care. I expand the concept of CHC beyond the doctor/patient interaction to show how fertility clinics mobilize CHC to institutionalize the ideal fertility traveler. This use of CHC, allows for an examination of how cross border reproductive care, which sometimes is marketed as a way to increase access to fertility care through the availability of treatment at (often) lower prices (Pennings 2002), can also act to further stratify reproduction (Cohen 1995, Ginsburg and Rapp 1995) as fertility clinics design their practices for particular types of (white and wealthy) clients. Thus, in using CHC to attract recipients to their clinics, fertility clinics may further stratify reproduction.

The findings that I relate in this dissertation have implications for future regulations surrounding the use of new biotechnologies for reproduction, such as egg donation. They also have implications for how sociologists and bioethicists view and understand the medical profession, commodities/gifts, and the use of cultural health capital by medical institutions in a global medical market.

IMPLICATIONS FOR SOCIAL AND BIOETHICAL THEORY

This research on the exchange of bodily goods through global medical markets lies at the intersections between several subfields of sociology and bioethics. I bring together these fields to investigate how legislation, medical practices, and ethics play out in people's lived experiences of medicine. These lived experiences have implications for the sociology of professions; economic sociology; sociology of health and illness; and empirical bioethics.

Sociology of professions and professional ethics

One of the key findings of this study is showing how the medical profession is able to maintain its authority over a restricted practice. I have used Gieryn's (1983) concept of boundary-work and Hughes' (1962) concept of dirty-work to show how the medical profession relies on scientific and medical discourse to remove itself from the more ethically contentious aspects of egg donation, the "dirty work." The restrictive legislation and the inability for the medical profession to recruit paid donors may have caused fertility clinics in Canada to recoil, eliminating the practice of egg donation from their practices. Instead, I show how medical professionals are able to cordon off their work to rely on the "scientific" problem of getting the egg and sperm together, thereby removing themselves from the aspects of egg donation that could be in contradiction of the act.

Sociologists examining how professionals respond to legislation should consider how professionals with authority redefine their work to remove ethically contentious aspects from their daily routine. As bioethicists consider how to best engage medical professionals in discussions surrounding ethics, they should understand how these medical professionals may use scientific rhetoric to disengage from ethical questions. Thus, ethical practices must be incorporated into medical professionals' standards of care so that these considerations become a routine part of "doing science" or "practicing medicine." One way to achieve this standardization is through appointing a specific set of professionals to ensure ethical standards are met. In the case of legislation surrounding egg donation, this legislation could specifically outline medical practitioners as the group of professionals responsible for ensuring that the standards of donation are met.

Economic sociology and ethical principles of consent

I have also argued that localized legislation, which attempts to restrict eggs from becoming commodities, ignores how commodification of eggs has already globally occurred. Local legislation that attempts to prevent the commodification of eggs ignores the material and social relationships that already exist as a result of this commodification. In recognizing the existence of commodified eggs and the relationships that have formed as a result of this commodification, I argue against the gift/commodity duality, showing how this duality creates false dichotomies between the "ethical" and the "unethical."

By going beyond this gift/commodity dichotomy, I provide an empirical understanding of the material and moral consequences of egg donation. One of these consequences is how the reproductive labour of egg donors is understood and valued. Previously, Cattapan (2016b) has made the philosophical argument that in legislating altruistic exchanges, the work that donors undertake to donate their eggs is overlooked and undervalued. In ignoring the "clinical labour" (Cooper and Waldby 2014) that these women perform to become egg donors, such as taking time off of work, undergoing a physically invasive procedure, their work is devalued. This devaluation is similar to other forms of feminine labour where women are expected to give without receiving anything in return (Almeling 2011, Hochschild 1983, Ogbogu 2019). Thus, I disrupt the “moral palatability” (Hovav 2019) of altruistic exchanges by complicating the existence of purely altruistic exchanges and showing how these altruistic exchanges rely on women providing free labour and potentially hide the coercive relationships that may exist within these supposedly neutral exchanges.

In complicating these relationships, I add to the existing body of work that has explicated the gendered power dynamics that exist within the exchange of body parts and wombs (Almeling 2011, Hovav 2019). I also point to the ways that undue influence can occur even when money is not exchanged, contributing to bioethical literature surrounding consent (Ells 2003, Faden and Beauchamp 1986, Levine et al. 2004). Thus, I bring together sociological and anthropological literature that has considered the relationships between gifts and commodities, (Fourcade and Healy 2007, Williams and Zelizer 2005, Zelizer 1979) while contributing to bioethical discourse on understanding of undue influence (Appelbaum et al. 2001, Faden and Beauchamp 1986, Fisher 2007).

Sociology of health and illness

The concept of cultural health capital (CHC) has been used to describe the ways that patients have mobilized their own knowledge and belief systems to create optimal relationships of care (Shim 2010). This work is important because it shows the ways that health care inequalities can be exacerbated based upon the ways in which patients interact with their health care providers and how health care providers perceive these interactions. In this study, I have begun to unpack how medical professionals also may mobilize cultural health capital to signal to potential clients that the care that they would receive at their clinic is acceptable. As medical markets become global and individuals travel abroad for medical services, including but not limited to fertility care, I argue that the strategies in action that these clinics mobilize may have potential implications for who, in turn, is seen as an acceptable/treatable health care consumer. That is, the institutionalization of cultural health capital (CHC) by medical clinics can serve to attract particular types of patients.

I have begun to imagine how this targeting of particular types of health care consumers could further stratify reproduction (Cohen 1995, Ginsburg and Rapp 1995). Since infertility largely remains an illness that is diagnosed more readily among white, affluent women (Greil et al. 2011b), the continued targeting of this population by international clinics could further entrench the idea of who is considered a potential fertility traveler. Although my work does not fully illuminate how the use of cultural health capital by fertility clinics to target white affluent fertility travelers may further exacerbate existing inequalities in diagnosis of infertility and access to fertility care, it shows how fertility clinics mobilize specific vernacular and scientific language to become more suitable for the affluent fertility tourist. My research is part of a growing body of work that shows how the global market for fertility care has not democratized fertility services, allowing more access to affordable fertility care (Franklin 2011, Martin 2015), but instead may contribute to the further stratification of reproduction.

The stratification of medical care through the targeting of specific types of health care consumers could be occurring in various other global fertility markets as patients try to access better and more advanced care outside of their home countries. Thus, my work complicates the idea that global medical markets provide for equalized medical access by offering care at different prices. In other words, I show how it is not just the price that may attract clients to medical services, but also the way that the services are marketed. To allow for affordable global access to care, these services must not only be attentive to the price of the care but the way that their medical clinics purport to meet the cultural expectations of their patients.

POLICY RECOMMENDATIONS

My work exposes how thinking of egg donation purely in terms of an altruistic exchange can overlook the ways that eggs are already being exchanged on the global market. This failure in observation creates three interrelated problems: 1) it suggests that altruistic relationships are necessarily morally good, ignoring the coercive relationships that may occur even within an altruistic exchange for eggs; 2) it undervalues the reproductive work of the women donors; and 3) it shifts the reproductive work to other countries where the practices of egg donation may be underregulated and less safe. The following policy recommendations based on my empirical examination of egg donation were crafted in order to overcome some of these interrelated problems.

Altruistic exchanges

I argue for a set compensatory system because it would help to standardize the expectations and costs of donation. As I have shown in this dissertation, these standardized systems are needed because egg donation (regardless of compensation) can create coercive relationships whereby donors are influenced to donate because of an external motivation. While donors should be reflective of the risks that they are incurring, the presumed necessity to donate out-of-altruism to avoid coercion, ignores the potential for other power-relationships that may exist or be created to obstruct a donor’s informed consent, even within altruistic exchanges.

As I have shown, monetary relationships are not the only things that can disrupt autonomous decision-making. Instead familial or friendship relationships can also place pressure on an individual woman to donate out of obligation. Since both monetary and altruistic donations, can produce nonconsensual donations, informed consent should not be presumed in altruistic exchanges. Thus, regulations should be created that center on the process of informed consent in egg donation, regardless of the mode of exchange.

Supporting the reproductive work of women through a set compensatory system

My work supports the conclusions of other researchers who have argued for the recognition of women's reproductive labour (Cattapan 2016b, Marre, Román and Guerra 2017, Smith 2015). This work highlights how women's bodies are often expected to care for and provide for others without any additional pay. Their work along with the research by Cooper and Waldby (2014) explicates how in relying on altruistic giving, the emotional and physical work of reproductive labour is undervalued. The devaluation of reproductive labour is reflective of the ways that women's work is often undervalued because of the expectation that women should altruistically give (Almeling 2011, Lewis 2019, Rudrappa and Collins 2015). Thus, in order to value reproductive labour, some argue for a set amount of payment to be given to donors (Bayefsky, DeCherney and Berkman 2016, Cooper and Waldby 2014) while others are more willing to allow market demands to guide the amount this labour is worth (Marre, Román and Guerra 2017). Below, I will argue that a set amount is morally preferable to a free market approach as it limits the cost of donation, provides transparency to how much a donor will receive, alleviates the bureaucratic burden of documenting expenses, and may allow Canada to have a self-sufficient system of donation.

One reason that a set compensatory amount is morally preferable to a market-based approach is because of the already staggering costs of donation that limit access to egg donation for certain recipients. In a free-market approach, supply and demand determines labour costs, and as the demand for donor eggs outweighs the supply, the costs in free-market locations can be excessively high ($8,000-$10,000). While recipients, in this study, were willing to pay donors for their work, they also noted how the cost of donation made it difficult for them to access treatment. Some even had to stop trying to conceive because of these costs. In placing a limit on compensation, prospective recipients are able to know how much an egg donation cycle will cost up front (something that I have found is not always the case in Canada). It also limits the financial burden on recipients by creating a set amount that donors should be given rather than relying upon market forces.

Another reason to provide a set amount for compensation is to allow prospective donors to know exactly the amount they will be given. The amount should be standardized across all donors so that donors of different races, ethnicities and socioeconomic stratum are not paid different amounts, which has been previously critiqued as putting a value on particular characteristics (Nahman 2013). By providing a set amount for women's reproductive labour, the problem of differentially valuing eggs because of their physical value is removed (Steinbock 2004). Instead, a woman's time and effort are compensated, rather than placing a value on her eggs. By paying for labour rather than for eggs, concerns surrounding the devaluation of human life through the pricing of human eggs may also be alleviated as it is the labour that is valued rather than the product/eggs produced.

Providing a set amount also alleviates the bureaucratic burden of documenting receiptable expenses, a task that often falls to the egg donor. It also removes the need for a fertility lawyer to negotiate a contract with the donor and the recipients as the expenses will already be standardized. While specialized contracts could be created, if the intended parent or the donor desired, the removal of a fertility lawyer from the steps of egg donation also eliminates the expense of a fertility lawyer.

Since an individual contract will no longer be needed, the entire egg donation contract should also be standardized to inform the donor and the recipients of their responsibilities and roles. It also should clearly define the risks to donation. By standardizing the egg donation contract and the amount reimbursed, both the risks of egg donation and the amount an egg donor will receive (partially for incurring those risks) will be made clear. This standardized contract allows any potential donor to look up the contract, the amount paid and the risks to egg donation before they contact an agency or fertility clinic. Thus, egg donors have the ability to understand the terms of donation before they contact a clinic or agency so that they are better able to ask questions surrounding the procedure and ultimately make an informed choice.

Regulating the safety of reproduction

The ability to pay egg donors for their labour may help to alleviate the need for Canadians to travel to other countries for egg donation. Baylis and Downie (2014) have previously argued that Canada should avoid relying on other markets for their eggs because of the lack of oversight that Canada has in these markets. That is, the ability for Canadians to find "cheap" eggs in other countries does not guarantee that the women who provided these eggs gave informed consent nor does it guarantee that their reproductive work was fairly valued. By paying egg donors a fixed amount for their eggs, Canadian women may be more likely to donate than they are under the current system both because the amount of money they would be given is set, and the amount is less legally ambiguous. Having a system that is self-sufficient is necessary as Canada could then set up proper regulations to help ensure the safety of donation (e.g., by regulating the type of protocol, for creating standards for reporting adverse effects, by setting limits on the number of times a donor can donate). A self-sufficient system, by definition, would decrease the need to travel to other countries for donation, potentially lessening the chance that

Canadians will take part in systems that exploit or coerce women into donating in other countries. It also ensures that Canadians (donors and recipients alike) are being provided with the standard of care, potentially eliminating adverse events that can happen as a result of not following the most up-to-date guidelines (e.g., the birth of multiples)[34].

A self-sufficient model is particularly appealing in Canada where all citizens have access to provincially-covered health care across their lifespan. This free access to health care is not afforded to donors in other countries, like the United States[35]. Universal access to health care across the lifespan is important not only in ensuring that egg donors have access to free health care if there is an adverse event (e.g., ovarian hyperstimulation) that occurs during treatment, but also to ensure health care access if the donor has any future medical complications (e.g., develops a reproductive cancer). Thus, a self-sufficient model in the Canadian context also has the added benefit of ensuring that a donor can receive proper medical care before, during and after the donation without any additional costs. Overall, an established Canadian system can ensure that donation is regulated, and risks are minimized by creating standardized practices of donation.

LIMITATIONS

While I have provided some recommendations to inform the future of the *AHRA*, this qualitative study of professionals and recipients' responses to the current iteration of the *AHRA* is not generalizable to other restrictive laws that may restrict certain medical treatments or practices of science. In analyzing how particular regulations impact the pathways that recipients use to

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[34] While the care that the Czech Republic and Spain provided to the patients in my sample did rely on these standards of care (and became a means to attract Canadian patients) not all countries (e.g., Cyprus) who provide egg donation to foreign patients follow the most recent standards of care.

[35] I specifically mention the United States here because of Canada's increasing reliance on frozen donor eggs from the US.

find donor eggs, I am able to show how the ability to receive medical care in other countries and the technological innovations that allow for the shipment of eggs across borders impacted these pathways. However, this research cannot be generalizable to other biotechnology legislation that may have more specified rules that attempt to curtail importations or where individuals lack the ability to travel to gain access to that particular technology. The fertility professionals' perspectives interactions with each other also impacted the ways that they saw themselves abiding by the law. Other regulation that attempts to regulate specific professions' actions (e.g., a law that specifies who is responsible for compensating the egg donor) rather than a practice that many professionals are involved in (e.g., all aspects of egg donation) may create different types of responses to ethical issues arising in their practices. In addition, laws that carry either more or less fines or jail time may also result in different responses to practitioners. While I sometimes suggest how laws may be created to better regulate practices, the effects of these laws should be empirically evaluated.

The Canadian fertility care professionals in my sample were interviewed eleven years after the laws had passed. This means that these fertility professionals may have inherited practices and beliefs from previous physicians at their clinic, possibly making them less likely to be able to judge how the *AHRA* actually affected their practice. In addition, after I concluded the interviews with the practitioners, a new amendment was proposed that affected the ways that *AHRA* defined compensation (see Philpott 2016). This amendment is currently not in force; thus, my research does not evaluate how these fertility practitioners feel about these new changes nor the affects that these changes may have on the practice of egg donation. While this amendment was being discussed, Anthony Housefather introduced a new bill that proposed to remove the restrictions on compensating donors (see Housefather 2018). Since this bill was introduced after

I had concluded my data collection, I also do not have information on how fertility practitioners or recipients feel about this law.

Another limitation of this research is that the number of respondents who accessed each type of pathway was relatively small and the travelers were limited to persons who had traveled to the Czech Republic. Individuals who traveled to other places may have had different experiences; however, my focus in this dissertation was on the process by which individuals choose those locations, rather than an evaluation of the care that they received. My supplementary data from individuals who had traveled to Mexico suggests that these processes are similar; however, future research should be done with individuals who travel to less established places.

While I did not restrict my sample to heterosexual women, only heterosexual women responded to my advertisement. Men's lack of response men may be due to the cultural belief that reproduction is solely a women's issue (Almeling 2015). Furthermore, men may not have felt comfortable responding to my flyers because egg donation is a treatment for female-factor infertility, possibly making it less likely that they would respond. The lack of LGBTQ+ individuals in my sample may be because women with female partners who are unable to conceive, use their partners' eggs and may not consider the use of those eggs as "egg donation". Men who have male partners may also not have responded to my flyer because they also used a surrogate, and thus, did not feel as if the narrow focus on egg donation applied to them. Future research should explore how these individuals' experiences with egg donors may differ from the respondents in my sample.

Furthermore, the few individuals that I recruited who had used a known donor in Canada may mean that individuals have experiences with recruiting a family member or friend or using a

Canadian agency that are not fully captured. In addition, as the number of individuals using frozen eggs grows and the number of clinics who provide this option to their patients increases, more research should be done on the process of importing frozen eggs from other countries as well as the ways that these eggs are treated as medical imports at borders.

I also presume that some individuals in need of donor eggs are not able to find them because of the restrictions placed on compensation. However, I did not talk to or recruit individuals who had decided not to pursue donation. While in this study many of the respondents had gone through egg donation within the past year, their accounts of their decisions were still dependent on the fact that they decided and were able to pursue egg donation.

Although I tried to gather a variety of stakeholder perspectives, this research does not capture the various experiences of egg donors who donate eggs under different legal jurisdictions. While women’s reasons for donating eggs should be considered when creating regulations that determine how their reproductive work should be valued, my research focused on the fertility care professionals and recipients’ practices. Some may argue that in overlooking egg donors opinions, this research further marginalizes the reproductive labour that these women undergo (Cattapan 2016b). While I understand these concerns and look forward to future sociological and bioethical work that studies these perspectives, I was unable to include donor perspectives because I was unable to find donors in Canada to interview and unable to speak enough Czech or Spanish to interview donors in these two countries. Thus, I choose to limit the scope of this dissertation to Canadian recipients and fertility care practitioners in hopes of better understanding how these stakeholders conceptualized their own decisions surrounding the ethical practice and receipt of egg donation. However, those that are donating likely have different views surrounding these practices.

DIRECTIONS FOR FUTURE RESEARCH

As mentioned above, this research does not capture the experiences of those who were told they needed an egg donor and decided not to pursue donation. It also relies on retrospective data, failing to capture the decision-making process as it is happening. Research that examines individuals decision-making processes from the time that they receive the news that they need a donor to their decision may help further illuminate the ways in which people decide whether to use an egg donor. This future research may also help alleviate the problem of relying on retrospective data by following participants through the decision-making process. Interview-based research that follows recipients through the process and interviews them at multiple time points could better evaluate how systemic hurdles, that allow for certain pathways and not others, may change how individuals think about their decisions. Coupling this research with observations in clinical encounters, including the fertility clinic, counselors' office and lawyers' office, would also help to illuminate how different professional bodies may or may not change recipient perspectives. Follow-up interviews with fertility professionals could also help to clarify why they counsel their patients/clients in certain ways. This work would provide an opportunity to see how fertility professionals guide recipients to morally rationalize their decisions. This semi-longitudinal study would also provide an opportunity to see how recipients' moral perspectives change or remain constant over the course of deciding to use an egg donor.

Future research should also collect data on how legislation in various countries affects the decisions of egg donors. While Pennings et al. (2014) have quantitatively examined the motivations and sociodemographic characteristics of donors donating under different types of European legislation, in-depth interviews should explore the actual decision-making of donors who donate under both restrictive legislation and more liberal legislation. This work could also explore the reasons that individuals may travel to another country to donate their eggs. If performed in the Canadian context, this work could also further illuminate if donors are being paid, despite the *AHRA.*

As the laws and regulations surrounding compensation continue to be debated in Canada, future research should also examine the ways that different stakeholders respond to challenges and clarifications of the *AHRA*. This work will allow for a better understanding of how fertility professionals respond to legislation that either limits or frees-up their practices. These research projects should also make sure to continue to consider those who will be affected by the change, recipients and egg donors. Although it may be difficult to interview future recipients and future donors, interviews with current egg donor recipients and egg donors that focus on their responses to the proposed changes of the act will allow for an understanding of how these changes may be received. In addition, research that evaluates the changes implemented should also be supported as this research will allow for a better understanding of the impacts that these laws have on the actual practices of reproductive medicine.

CONCLUDING REMARKS

This dissertation follows the pathways that Canadian women take to find donor eggs under a restrictive law and the Canadian and international fertility professionals' practices who may care for these recipients in order to better understand how laws that regulate reproductive practices are morally understood and implemented. These pathways and practices have provided a more nuanced understanding of how eggs are exchanged in a global market by focusing on the empirical realties of egg donation. I have shown how medical professionals may use practices of science and medicine to avoid discussions of ethics, and how international medical professionals engage with certain medical and scientific rhetoric to attract patients to their clinics. My dissertation exposes how laws and medical practices come together to affect recipients' experiences of care and how these practices and experiences can help shape the ways that eggs are morally conceptualized. I hope that this research will be useful in exploring alternative ways of regulating reproduction that recognize the existing global trade in eggs while providing protections for those who donate and receive eggs.

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Appendix A
Assisted Human Reproduction Act

The following was taken directly from the English version of the Assisted Human Reproduction Act. It should not be reproduced without proper citation. The full act can be found at https://laws-lois.justice.gc.ca/eng/acts/a-13.4/

Official status of consolidations

Subsections 31(1) and (2) of the Legislation Revision and Consolidation Act, in force on June 1, 2009, provide as follows:

Published consolidation is evidence
31 (1) Every copy of a consolidated statute or consolidated regulation published by the Minister under this Act in either print or electronic form is evidence of that statute or regulation and of its contents and every copy purporting to be published by the Minister is deemed to be so published, unless the contrary is shown.

Inconsistencies in Acts
(2) In the event of an inconsistency between a consolidated statute published by the Minister under this Act and the original statute or a subsequent amendment as certified by the Clerk of the Parliaments under the Publication of Statutes Act, the original statute or amendment prevails to the extent of the inconsistency.

NOTE
This consolidation is current to February 28, 2017. The last amendments came into force on September 30, 2012. Any amendments that were not in force as of February 28, 2017 are set out at the end of this document under the heading "Amendments Not in Force".[36]
S.C. 2004, c. 2

An Act respecting assisted human reproduction and related research
[Assented to 29th March 2004]

Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

Short title
1 This Act may be cited as the Assisted Human Reproduction Act.

Principles

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[36] The "Amendments not in force": have been deleted from this Appendix.

Declaration

2 The Parliament of Canada recognizes and declares that

(a) the health and well-being of children born through the application of assisted human reproductive technologies must be given priority in all decisions respecting their use;

(b) the benefits of assisted human reproductive technologies and related research for individuals, for families and for society in general can be most effectively secured by taking appropriate measures for the protection and promotion of human health, safety, dignity and rights in the use of these technologies and in related research;

(c) while all persons are affected by these technologies, women more than men are directly and significantly affected by their application and the health and well-being of women must be protected in the application of these technologies;

(d) the principle of free and informed consent must be promoted and applied as a fundamental condition of the use of human reproductive technologies;

(e) persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis of their sexual orientation or marital status;

(f) trade in the reproductive capabilities of women and men and the exploitation of children, women and men for commercial ends raise health and ethical concerns that justify their prohibition; and

(g) human individuality and diversity, and the integrity of the human genome, must be preserved and protected.

Interpretation and Application

Definitions

3. The following definitions apply in this Act.

chimera means

(a) an embryo into which a cell of any non-human life form has been introduced; or

(b) an embryo that consists of cells of more than one embryo, foetus or human being.

donor means

(a) in relation to human reproductive material, the individual from whose body it was obtained, whether for consideration or not; and

(b) in relation to an in vitro embryo, a donor as defined in the regulations. (donneur)

embryo means a human organism during the first 56 days of its development following fertilization or creation, excluding any time during which its development has been suspended, and includes any cell derived from such an organism that is used for the purpose of creating a human being. (embryon)

foetus means a human organism during the period of its development beginning on the fifty-seventh day following fertilization or creation, excluding any time during which its development has been suspended, and ending at birth.

gene includes a nucleotide sequence, and an artificially created gene or nucleotide sequence.

genome means the totality of the deoxyribonucleic acid sequence of a particular cell.

human clone means an embryo that, as a result of the manipulation of human reproductive material or an in vitro embryo, contains a diploid set of chromosomes obtained from a single — living or deceased — human being, foetus or embryo.

human reproductive material means a sperm, ovum or other human cell or a human gene, and includes a part of any of them.

hybrid means

- (a) a human ovum that has been fertilized by a sperm of a non-human life form;
- (b) an ovum of a non-human life form that has been fertilized by a human sperm;
- (c) a human ovum into which the nucleus of a cell of a non-human life form has been introduced;
- (d) an ovum of a non-human life form into which the nucleus of a human cell has been introduced; or
- (e) a human ovum or an ovum of a non-human life form that otherwise contains haploid sets of chromosomes from both a human being and a non-human life form.

in vitro embryo means an embryo that exists outside the body of a human being.

Minister means the Minister of Health

ovum means a human ovum, whether mature or not

sperm means a human sperm, whether mature or not

surrogate mother means a female person who — with the intention of surrendering the child at birth to a donor or another person — carries an embryo or foetus that was conceived by means of an assisted reproduction procedure and derived from the genes of a donor or donors

Her Majesty bound

4 This Act is binding on Her Majesty in right of Canada or a province.

Non-application

4.1 The Human Pathogens and Toxins Act does not apply in respect of sperm, ova and in vitro embryos to be used for the purpose of assisted human reproduction.

Prohibited Activities

Prohibited procedures

5 (1) No person shall knowingly

- (a) create a human clone by using any technique, or transplant a human clone into a human being or into any non-human life form or artificial device;
- (b) create an in vitro embryo for any purpose other than creating a human being or improving or providing instruction in assisted reproduction procedures;
- (c) for the purpose of creating a human being, create an embryo from a cell or part of a cell taken from an embryo or foetus or transplant an embryo so created into a human being;
- (d) maintain an embryo outside the body of a female person after the fourteenth day of its development following fertilization or creation, excluding any time during which its development has been suspended;
- (e) for the purpose of creating a human being, perform any procedure or provide,

prescribe or administer any thing that would ensure or increase the probability that an embryo will be of a particular sex, or that would identify the sex of an in vitro embryo, except to prevent, diagnose or treat a sex-linked disorder or disease;
(f) alter the genome of a cell of a human being or in vitro embryo such that the alteration is capable of being transmitted to descendants;
(g) transplant a sperm, ovum, embryo or foetus of a non-human life form into a human being;
(h) for the purpose of creating a human being, make use of any human reproductive material or an in vitro embryo that is or was transplanted into a non-human life form;
(i) create a chimera, or transplant a chimera into either a human being or a non-human life form; or
(j) create a hybrid for the purpose of reproduction, or transplant a hybrid into either a human being or a non-human life form.

Offers

(2) No person shall offer to do, or advertise the doing of, anything prohibited by this section.

Payment for prohibited act

(3) No person shall pay or offer to pay consideration to any person for doing anything prohibited by this section.

Payment for surrogacy

6 (1) No person shall pay consideration to a female person to be a surrogate mother, offer to pay such consideration or advertise that it will be paid.

(2) No person shall accept consideration for arranging for the services of a surrogate mother, offer to make such an arrangement for consideration or advertise the arranging of such services.

Payment to intermediaries

(3) No person shall pay consideration to another person to arrange for the services of a surrogate mother, offer to pay such consideration or advertise the payment of it.

Surrogate mother — minimum age

(4) No person shall counsel or induce a female person to become a surrogate mother, or perform any medical procedure to assist a female person to become a surrogate mother, knowing or having reason to believe that the female person is under 21 years of age.

Validity of agreement

(5) This section does not affect the validity under provincial law of any agreement under which a person agrees to be a surrogate mother.

Purchase of gametes

7 (1) No person shall purchase, offer to purchase or advertise for the purchase of sperm or ova from a donor or a person acting on behalf of a donor.

Purchase or sale of embryos

(2) No person shall

(a) purchase, offer to purchase or advertise for the purchase of an in vitro embryo; or **(b)** sell, offer for sale or advertise for sale an in vitro embryo.

Purchase of other reproductive material

(3) No person shall purchase, offer to purchase or advertise for the purchase of a human cell or gene from a donor or a person acting on behalf of a donor, with the intention of using the gene or cell to create a human being or of making it available for that purpose.

Exchanges included

(4) In this section, “purchase” or “sell” includes to acquire or dispose of in exchange for property or services.

Use of reproductive material without consent

8 (1) No person shall make use of human reproductive material for the purpose of creating an embryo unless the donor of the material has given written consent, in accordance with the regulations, to its use for that purpose.

Posthumous use without consent

(2) No person shall remove human reproductive material from a donor’s body after the donor’s death for the purpose of creating an embryo unless the donor of the material has given written consent, in accordance with the regulations, to its removal for that purpose.

Use of in vitro embryo without consent

(3) No person shall make use of an in vitro embryo for any purpose unless the donor has given written consent, in accordance with the regulations, to its use for that purpose.

Gametes obtained from minor

(9) No person shall obtain any sperm or ovum from a donor under 18 years of age, or use any sperm or ovum so obtained, except for the purpose of preserving the sperm or ovum or for the purpose of creating a human being that the person reasonably believes will be raised by the donor.

(10) [Repealed, 2012, c. 19, s. 717] 10 [Abrogé, 2012, ch. 19, art. 717]

(11) [Repealed, 2012, c. 19, s. 718]

Responsibility of Minister

[Not included in this Appendix as it surrounds the implementation and changing of the law, which is not the subject of this dissertation.

Appendix B
Interview Guides

INTERVIEW GUIDE FOR CANADIAN FERTILITY CLINICS

Thank you so much for agreeing to participate in this interview. Before we get started, I want to confirm that you understand the consent form and have signed it. Do you have any questions for me before we begin? Now, I'm going to ask you a series of questions about your experience as a fertility care professional. There are no "right" or "wrong" answers and there's no such thing as too long an answer (or "talking too much") – what I'm interested in is your experiences, thoughts and feelings. So, please relax and take your time in answering the questions. Also, please feel free to tell me if there are any questions you prefer not to answer or, if at any time, you need to take a break or wish to stop the interview. Is it okay if I record the interview so that I can better listen to your experiences? (Wait for response). You may ask me to turn of the recorder at any time during the interview. Thank you again for agreeing to be interviewed.

1. Can you describe to me your role in the clinic?
2. How does your clinic attempt to meet the needs of your patients? What are the things that help you meet patients' needs? What are the things that make it hard to meet patients' needs?
    a. Do any of these limitations mean that you must refer patients outside of your clinic
3. Do you see patients that require the use of an egg donor?
4. How do your patients go about finding an egg donor?
    a. What types of information is given to them about the donor?
    b. Are the donors that your clients use anonymous or known?
5. Does your clinic have its own pool of donors? (If yes, continue)
    a. How do you find the donors that your clinic works with?
    b. What is the process of becoming an egg donor?
        i. Are there any genetic tests that your clinic requires?
    c. Can you describe to me what a stimulation cycle looks like at your clinic?
    d. Who works with the donors?
        i. Is there a separate person who works with the donor and the patient?
    e. Is your clinic affiliated with a donor bank?
        i. Can you please describe to me this relationship?
        ii. Do you know what is required to be an egg donor at this egg bank?
            1. Tests?
            2. Stimulation protocol?
        iii. <u>If no,</u> why doesn't your clinic work with egg banks?
6. If the clinic has an out-of-country affiliation—
    a. How did you decide to work with this clinic?

        i. Factors (safety? quality of eggs? Relationship with donors?)
    b. How do your clients go about working with the (name of clinic)?
        i. What types of information about the patient do you provide to this clinic?
        ii. How do you facilitate this relationship?
            1. If the client works solely with the clinic—how do you ensure that your patient receives the gametes that they need?
    c. Do you know what is required for women at this clinic to become an egg donor?
        i. Tests?
        ii. Stimulation protocol?

7. How much does a donor egg cycle cost at your clinic?
    a. How much of this money is given to the:
        i. Outside agency?
        ii. Your clinic?
    b. How does the payment work?
        i. If outside services, does the client pay the outside agency directly?
8. Is the egg donor reimbursed anything for her services?
    a. How much? does the payment work? (Who is paid? What are they paid for?)
9. For those patients who decide to use a donor, do you know if they decide to tell their conceived children?
10. What may be some of the reasons that your patients decide not to use an egg donor?
    a. Genetics?
    b. Lack of availability?
11. What is your interpretation of the Assisted Human Reproduction Act of Canada regarding compensation to egg donors?
    a. How do you think this law affects the ability of egg donors? Of patient care?
12. Do you refer patients outside of your clinic for any other services? Why?
    a. Where would you refer your patients?
        i. Specific countries? US? MX? CZ?
13. Do you follow-up with patients after they receive fertility care in other countries? If so, what are their experiences?
14. Do some patients decide not to pursue treatment in other locations? What do you think are the factors that contribute to patients staying at home?
15. Do you have any concerns about cross border reproductive care?
    a. Are any of these concerns location specific?
16. Do you think that any policies such as the Assisted Human Reproduction Act lead to an increase number of people seeking reproductive care outside of Canada?
17. In the future, do you think that infertility care provided outside of Canada will continue to increase?
18. How does fertility care in Canada need to change in order to decrease the practice of CBRC?

Appendix B Interview guides

INTERVIEW GUIDE FOR CANADIAN FERTILITY COUNSELORS

Thank you so much for agreeing to participate in this interview. Before we get started, I want to confirm that you understand the consent form and have signed it. Do you have any questions for me before we begin? Now, I'm going to ask you a series of questions about your experience as a fertility counselor. There are no "right" or "wrong" answers and there's no such thing as too long an answer (or "talking too much") – what I'm interested in is your experiences, thoughts and feelings. So, please relax and take your time in answering the questions. Also, please feel free to tell me if there are any questions you prefer not to answer or, if at any time, you need to take a break or wish to stop the interview. Is it okay if I record the interview so that I can better listen to your experiences? (Wait for response). You may ask me to turn of the recorder at any time during the interview. Thank you again for agreeing to be interviewed.

1. Can you describe to me your role as a fertility counselor?
    a. Are you affiliated with a particular fertility clinic?
2. How are patients referred to you? What types of patients do you generally see?
3. Do you see patients that require the use of an egg donor?
4. How do you counsel these patients?
    a. What types of information do you provide to them?
5. What are the main concerns that these patients have?
        i. Genetic concerns?
        ii. How do you see your role in counseling these patients?
6. What proportion of your patients decide not to continue with donor eggs?
    a. Why?
    b. What are some of the challenges that Canadian's face when finding donor eggs?
7. Of those that decide to continue to pursue treatment, how do they come to this decision?
    a. Are these patients looking for advice on anonymous vs. non-anonymous donors?
        i. How do you counsel them?
            1. What are the benefits of working with anonymous donors? The drawbacks?
    b. What types of relationships do your patients generally have with their non-anonymous donors?
        i. Are there certain things that persons who know their donors should put into place before deciding on using the donor?
        ii. Does this counseling differ based on if the donor is a close family member or friend?
    c. If patients cannot find an anonymous donor, what are their options?
        i. Do some of your patients decide to travel to other countries?
        ii. Use frozen egg banks?
        iii. Are you involved in any way in that decision-making process?
            1. What may be some of the concerns of patients who travel?
            2. Of who use donated frozen eggs?

8. How do you advise intended parents regarding the knowledge that their future offspring may have of donation?
9. How do you counsel patients regarding telling other family members or friends?
    a. What types of things should these patients take into consideration?
10. Are you in contact with these patients after they pursue a donated egg cycle?
    a. If so, what does this contact look like?

Donor Counseling

11. Are you involved in counseling potential donors?
12. What is your role?
13. How do you talk about the genetic connection that these donors have to their donated gametes?
    a. What concerns arise from the donors in this manner?
    b. How do the donors talk about the relatedness that they may or may not feel that they have?
14. How do you counsel donors who are going to be known donors?
    a. Are their specific topics that you cover with these donors that you would not cover with anonymous donors?
    b. How do you advise them to communicate with the intended parents? Does this relationship differ?
15. Are you involved in any way with anonymous donors?
    a. What does this relationship look like?

Assisted Human Reproduction Act

16. What is your interpretation of the Assisted Human Reproduction Act of Canada regarding compensation to egg donors?
    a. How do you think this law affects the ability of egg donors? Of patient care?
    b. Do patients ask you for an interpretation of this act?
17. What is your surrounding the ability to compensate or not compensate egg donors?
18. Do you see the compensation changing in the future?
    a. What are the benefits to compensation?
    b. Drawbacks?

Appendix B Interview guides

INTERVIEW GUIDE FOR CANADIAN FERTILITY LAWYERS

Thank you so much for agreeing to participate in this interview. Before we get started, I want to confirm that you understand the consent form and have signed it. Do you have any questions for me before we begin? Now, I'm going to ask you a series of questions about your experience as a fertility lawyer. There are no "right" or "wrong" answers and there's no such thing as too long an answer (or "talking too much") – what I'm interested in is your experiences, thoughts and feelings. So, please relax and take your time in answering the questions. Also, please feel free to tell me if there are any questions you prefer not to answer or, if at any time, you need to take a break or wish to stop the interview. Is it okay if I record the interview so that I can better listen to your experiences? (Wait for response). You may ask me to turn of the recorder at any time during the interview. Thank you again for agreeing to be interviewed.

1. Can you describe to me your role in legally advising fertility clients?
    a. What types of clients do you see?
2. Do you see clients that require the use of an egg donor?
    a. Are they advised to come and see you by their fertility clinic?
3. Do you work with particular fertility clinics?
    a. If so, can you describe your relationship with these clinics?
4. Why might clients who need an egg donor come to see you?
    a. Of clients that come and work with you, how are they finding their donors?

<u>Assisted Human Reproduction Act</u>

5. Can you describe to me your interpretation of section 7 of the Assisted Human Reproduction Act?

    Purchase of gametes
    7 (1) *No person shall purchase, offer to purchase or advertise for the purchase of sperm or ova from a donor or a person acting on behalf of a donor.*
    Marginal note: Purchase or sale of embryos
    (2) *No person shall*
        (a) *purchase, offer to purchase or advertise for the purchase of an in vitro embryo; or*
        (b) *sell, offer for sale or advertise for sale an in vitro embryo.*

6. Are there different interpretations of this section other than the one that you just provided?
    a. If so, what are these different interpretations?
7. Do clinics ask you for assistance in interpreting this act?
    a. If so, how do you advise them?
8. Do you see fertility clinics interpreting this section differently?
    a. If so, how?
    b. Why might this different interpretation occur?
9. Does this section result in people obtaining different types of treatment at different locations?

10. Does this section result in different types of donor contracts?
    a. If so, how?
    b. What are these contracts?
11. How does this section affect the ability of donor eggs in Canada?
12. What other options do your clients use in order to find a donor egg?

People who use Canadian donors

13. Do you help clients who use donor eggs in Canada?
14. What types of relationships do your clients have with these donors?
    a. How, generally, have your clients found these donors?
    b. How are these contracts between donors and clients structured?
        i. What types of legal issues are you looking out for?
15. Do any of these clients use a donor egg bank in Canada?
    a. Do you advise them to use these donor egg banks?
16. In your opinion, how do the Canadian donor egg banks find donors?
    a. Is there any sort of compensation being provided to these donors?
    b. If so, how does this fit into the AHR?

People who use frozen eggs or embryos from the United States

17. Do you advise clients who use frozen eggs or embryos from the United States?
18. Do you know how this process works?
19. How do these actions fit into the AHR?
    a. How does the payment work?
    b. How is the "compensation" that is provided to egg donors in the US viewed under the act?
        i. Do you see this compensation as being different from compensating donors directly in Canada?
20. How do you "legally" see the relationships that some clinics have with the donor egg banks in the United States?
    a. Are there any legal challenges with establishing these relationships or shipped eggs?
        i. What are these challenges?

People who travel

21. How do you think the Assisted Human Reproduction Act leads to people seeking reproductive care outside of Canada?
22. How do you see this travel under the act?
23. Do you know what locations these people travel to?
    a. Are there any legal complications that arise with this travel?

Other sections of the Act

24. Why do you think that the act prohibits compensation?
    a. Is this prohibition related to any of the other sections in the act?
        i. How might section 2 be related to section 7?
            1. In particular ask about section f?

> *Section 2 c states*--
> ***(c)*** *while all persons are affected by these technologies, women more than men are directly and significantly affected by their application and the health and well-being of women must be protected in the application of these technologies;*
>
> *Section 2d states—*
> ***(d)*** *the principle of free and informed consent must be promoted and applied as a fundamental condition of the use of human reproductive technologies;*
>
> *Section 2f states—*
> ***(f)*** *trade in the reproductive capabilities of women and men and the exploitation of children, women and men for commercial ends raise health and ethical concerns that justify their prohibition; and*

25. What is your opinion of the act?
26. How do you think it came into place?
27. Are there any sections of the act that:
    a. Should be clarified?
    b. Should be changed?
28. What are the biggest benefits of the act?
29. Does the act have any drawbacks? If so, what are these?

Appendix B Interview guides

INTERVIEW GUIDE FOR FERTILITY PATIENTS

Thank you so much for agreeing to participate in this interview. Before we get started, I want to confirm that you understand the consent form and have signed it. Do you have any questions for me before we begin? Now, I'm going to ask you a series of questions about your experience as a fertility patient. There are no "right" or "wrong" answers and there's no such thing as too long an answer (or "talking too much") – what I'm interested in is your experiences, thoughts and feelings. So, please relax and take your time in answering the questions. Also, please feel free to tell me if there are any questions you prefer not to answer or, if at any time, you need to take a break or wish to stop the interview. Is it okay if I record the interview so that I can better listen to your experiences? (Wait for response). You may ask me to turn of the recorder at any time during the interview. Thank you again for agreeing to be interviewed.

Introduction

1. First off, I would like to learn a little about your reproductive history?
2. Can you describe to me your fertility journey beginning with the first time you began to try to conceive?
    a. Make sure to determine if it is secondary infertility.
    b. Cause of infertility.
    c. Also ask about obtaining procedures in home country before going to another country.

For patients who had traveled decision to undergo CBRC

3. How did you decide where to receive treatment?
    a. Did you talk to other fertility patients' before going?
        i. How did you communicate with them?
    b. How did you find information?
        i. Clinic websites, forums, etc.
    c. Were you considering any other countries?
    d. What treatment(s) were you looking for?
    e. If received consultation in Canada first, did your clinic in Canada advise a specific clinic?
4. What were the specific benefits in gaining treatment at this location? (in Canada vs. outside or outside vs. Canada)
    a. What kind of care did the clinic you choose provide?
5. If outside of Canada, what were your main concerns about traveling abroad for fertility care?
    a. How did you alleviate these concerns?

Obtaining IVF involving egg donation

6. How did you go about securing treatment?

    a. Ask about contact with fertility director or external organization.
7. Did anything make it easier to receive care in X?
8. Did anything make it more difficult to receive care in X?
9. Can you walk me through the procedures you received at X?
    a. *Egg donation*
        i. How did you decide to use an egg donor?
        ii. Were you able to pick the donor?
            1. How did you go about choosing an egg donor?
            2. What characteristics were important for you in choosing an egg donor?
                a. Physical?
                b. Behavioral?
                c. Health?
            3. Was donor anonymity a concern for you? Why or why not?
            4. How satisfied were you with the matching services the clinics' provided?

Demographics:

10. Age?
11. Ethnicity/race?
12. Sexual orientation?
13. Highest level of education?
14. Average annual household income?
15. Province?

Appendix B Interview guides

INTERVIEW GUIDE FOR CANADIAN EGG BANKS

Thank you so much for agreeing to participate in this interview. Before we get started, I want to confirm that you understand the consent form and have signed it. Do you have any questions for me before we begin? Now, I'm going to ask you a series of questions about your experience as a manager of an egg bank. There are no "right" or "wrong" answers and there's no such thing as too long an answer (or "talking too much") – what I'm interested in is your experiences, thoughts and feelings. So, please relax and take your time in answering the questions. Also, please feel free to tell me if there are any questions you prefer not to answer or, if at any time, you need to take a break or wish to stop the interview. Is it okay if I record the interview so that I can better listen to your experiences? (Wait for response). You may ask me to turn of the recorder at any time during the interview. Thank you again for agreeing to be interviewed.

1. Can you describe to me your role as the XXXX of the donor bank?
2. How was this service developed?
3. What is your relationship with Canadian fertility clinics?
    a. How have you come to work with these clinics?
    b. Are there specific requirements that these clinics must have so that you can work with them? If so, what are they?
    c. What things make it easier to work with these clinics? More difficult?
4. How are patients generally referred to your bank?
5. Are you involved at all in determining what types of care these patients receive?
6. What happens if a client wants to use your services for donor eggs?
    a. Can you describe to me the process?
    b. Is there anything that would make you not work with a Canadian client?
    c. How much does a donor egg generally cost/what are your packages?
7. What types of characteristics are patients wanting to find in an egg donor?
    a. Are you generally able to meet their desires?
    b. How do you attempt to have a selection of donors available?
8. How does your bank operate in terms of finding egg donors?
    a. Where do your donors come from?
        i. U.S? Canada?
9. What are the requirements of becoming an egg donor?
    a. Health tests?
    b. Genetic tests?
    c. Social characteristics?
10. Are the egg donors compensated in any way in the US?
    a. How do you see this compensation fitting into Canada's Assisted Human Reproduction Act?
11. What is the process of bringing the frozen eggs into Canada?
    a. Do you have to pay an import tax on these eggs? Do the clients pay for this directly or is it covered in the total costs?

12. Does the clinic or the patient purchase the donor eggs?
    a. How does the clinic or patient receive the eggs?
13. What is your interpretation of the Assisted Human Reproduction Act of Canada regarding compensation to egg donors?
    a. How do you think this law affects the ability of egg donors? Of patient care?
14. Are their specific regulations that you must abide by?
    a. Are any of these determined by Health Canada?
        i. What does an inspection by Health Canada look like?
            1. Are they interested in how eggs are retrieved in the US?
15. How do you think policies such as the Assisted Human Reproduction Act affect your practice?
16. Do you see this policy changing in the future? Why or why not?
17. Besides working with fertility clinics are there any other health or other fertility professionals that you work with?
    a. Counselors?
    b. Lawyers?

Appendix B Interview guides

INTERVIEW GUIDE FOR INTERNATIONAL FERTILITY PROFESSIONALS

Thank you so much for agreeing to participate in this interview. Before we get started, I want to confirm that you understand the consent form and have signed it. Do you have any questions for me before we begin? Now, I'm going to ask you a series of questions about your experience as a fertility care professional. There are no "right" or "wrong" answers and there's no such thing as too long an answer (or "talking too much") – what I'm interested in is your experiences, thoughts and feelings. So, please relax and take your time in answering the questions. Also, please feel free to tell me if there are any questions you prefer not to answer or, if at any time, you need to take a break or wish to stop the interview. Is it okay if I record the interview so that I can better listen to your experiences? (Wait for response). You may ask me to turn of the recorder at any time during the interview. Thank you again for agreeing to be interviewed.

1. First, I'd like to ask you about your role in the clinic. Can you describe to me what a typical day looks like for you?
2. (If not already mentioned). Do you see international patients?
    a. Where do they come from?
    b. How do these procedure or treatments differ from the services you provide to your local patients? How are these procedures the same?
3. Can you describe to me what you believe attracts international patients to this clinic?
4. What types of challenges do you face when interacting with international patients?
    a. Probe. Language barriers?
    b. How do you believe that your clinic is able to meet international patients' needs?
5. You mentioned above that your clinic provides IVF. I would like to ask you a few questions about the use of donor eggs in your practice.

Egg Donation

6. Does your clinic recruit egg donors for the purposes of IVF?
7. What types of screening is required for egg donor?
8. Donor characteristics.
    a. What is the average age of the egg donor?
    b. What is the average income of an egg donor?
    c. What is the average education of an egg donor?
9. Are the donors provided any compensation/reimbursement for their services?
    a. How is this compensation determined?
10. Are donors allowed to make any demands on how their eggs are used?

Now I will ask a few questions regarding your IVF patients and their use of egg donors.

11. About how many of your international patients require the use of an egg donor?
12. How do patients choose the egg donor?
13. Does your clinic attempt to phenotypically match donors to patients?
    a. How is this done?

14. How do you think your clinic is able to match these patients' desires?
15. Are there any other additional matching services or tests that you offer your patients?
    a. What are they?
    b. Why do you think they are important?

Future of Clinic/Fertility Care

16. How do you think reproductive care will change in the future?
17. How do you think policies will affect this?
18. Do you think that the practice of travelling for reproductive services will increase?
19. How do you see this clinic progressing in the future?
20. What is your perspective on cross border reproductive care?
21. Is there anything else you would like to add?

Appendix C Recipients' characteristics (n=20)

	No. of interviews (Total interview length in mins)	Race	Household Income (CAD)	Education	Age (Age at tx)	Marital Status, Sexual Orientation	Diagnosis	Outcome	Method of finding donor	Donor relation	Appx. total cost of treatment
Recipients who stayed in Canada (n=12)											
Fae	1 (55)	Filipino	$120,000	High school diploma	43	Married, hetero	Age, endometriosis	1 transfer; Unknown	Family	Known-sister	$11,000
Madeline	1 (45)	White	>$100,000	University	42	Married, hetero	Endometriosis, fibroids, low follicle count	1 transfer Unknown	Friend	Known-friend	$20,000
Phoebe	3 (136)	White	NR	University	41	Single, hetero	Low anti-Mullerian hormone	1 failed; miscarriage	Canadian agency	Known	$25,000-$30,000
Sam	2 (101)	White	$70,000	Master's	43	Partnered, hetero	Low follicle count, low anti-Mullerian hormone	2 failed transfers	Canadian agency	Known	>$35,000
Nora	1 (70)	White	$55,000	University	43 (39)	Married, hetero	Early Menopause	1 success; 1 child	United States agency	Known	$35,000
Naomi	1 (65)	White	$150,000	Master's	45 (43)	Married, hetero	Age-related, immunity with partner	1 success; 1 child	United States agency	Anonymous	NR
Alex	1 (60)	White	$125,000	University	29	Married, hetero	Premature ovarian failure	1 failed 1 success (w/frozen	Sister, United States	Sister, anonymous	NR

Appendix C Recipient characteristics

								eggs); 1 child	frozen egg bank		
Rhonda	1 (55)	White	NR	University	NR	Married, hetero	Diminished ovarian reserve	1 success; 1 child	United States frozen egg bank	Anonymous	$22,000
Cathy	1 (75)	White	$250,000	Master’s	43	Married, hetero	Age-related, diminished ovarian reserve	1 success; 1 child	United States frozen egg bank	Anonymous	$55,000
Meredith	2 (87)	White	$180,000	University	37	Married, hetero	Poor egg quality	1 failed donor cycle, became pregnant naturally; 1 child	United States frozen egg bank	Anonymous	$21,000
Martha	1 (71)	Mixed-race	$100,000	Master’s	40	Married, hetero	Unexplained	1 failed; miscarriage	United States frozen egg bank	Anonymous	$25,000
Lori	1 (40)	White	$180,000	University	33	Married, hetero	Premature ovarian failure caused by Mosaic Turner’s Syndrome	1 success; 1 child	United States frozen egg bank	Anonymous	$36,000
Fertility Travelers (n=8)											
Macie	1 (55)	White	$170,000	University	38	Married, hetero	Endometriosis	1 success; 1 child	Czech Republic	Anonymous	NR
Sara	1 (65)	White	$150,000	University	46	Married, hetero	Age-related	1 success; twins	Czech Republic	Anonymous	$8,000
Jacky	1 (60)	White	$90,000	University	39	Married, hetero	Low follicular count	1 success;	Czech Republic	Anonymous	$10,000

Appendix C Recipient characteristics

								twins			
Josey	1 (63)	White	$150,000	University	35	Married, hetero	Endometriosis	1 success; 1 child	Czech Republic	Anonymous	$8,000
Abigail	1 (65)	White	$140,000	University	40	Married, hetero	Primary ovarian failure	3 failed transfers	Czech Republic	Anonymous	NR
Andrea	1 (105)	White	$122,000	Some university	46	Married, hetero	Age-related, endometriosis, blocked fallopian tube, fibroids	2 failed; 1 success; 1 child	Czech Republic	Anonymous	$10,000
Sophia	1 (85)	White	$65,000[2]	University	42	Married, hetero	Age-related infertility	2 failed; 1 success 1 child	Czech Republic	Anonymous	$13,000
Stephanie	1 (60)	White	$36,000	Masters	49	Single, hetero	Age, autoimmune condition; secondary infertility	2 failed transfers	Czech Republic	Anonymous	NR

TX=Treatment; NR=No response. Total number of interviews=24. Average time per interview=67 minutes

Appendix D Reflections on positionality

A feminist approach to research necessitates that one take into consideration how their own positionality as a researcher may have affected their abilities to conduct research, the way that their respondents viewed them and their interpretation of their findings (Reinharz 1992). In this methodological Appendix, I define my own positionality and how it both aided and hindered my research.

MCGILL AS CULTURAL CAPITAL

As a young white woman coming from an upper-middle class background and attending McGill, a prestigious university, I was acutely aware how I could mobilize my social and cultural capital (Bourdieu 1986) to garner trust in potential interviewees. That is, being a graduate student at an internationally recognized university may have provided me with access to overseas and current fertility professionals and recipients of egg donation. In my recruitment efforts for all participant categories, I choose to highlight this aspect, assuming that individuals would want to help a graduate student, especially one that attended a well-known university. While fertility professionals and recipients in Canada may have allowed me to interview them regardless of the prestige of my university, I found that the name McGill resounded with the international fertility professionals in ways that generally (although not always) provided me with access to international professionals.

In most instances, my affiliation with McGill helped me gain access to the fertility clinics in the Czech Republic and Spain as they recognized the university name and thus, the legitimacy of me as a researcher. Sometimes as the medical professionals were walking with me to a private conference room, they would say something positive about McGill “it’s a good university” or ask me a question surrounding my studies there. At the same time, my affiliation with McGill may have been a reason why I did not gain access to clinics in the Czech Republic.

There were two known instances when my McGill affiliation prevented me from interviewing a fertility representative. One clinic in the Czech Republic boasts an affiliation with McGill. While McGill does not advertise a relationship with the clinic in the Czech Republic, this clinic claims an affiliation with a physician who once led the reproductive center at McGill. I have not tried to verify this affiliation, but in my attempts to contact this McGill-affiliated clinic about a potential interview, I was first granted an appointment and then denied based on the clinic's "policy on confidentiality and clinical operation best practices." In another instance, my affiliation with McGill was seen as a "conflict of interest" as the clinic feared that I would share my information with the "McGill affiliated clinic." I responded to both refusals by clarifying my research objectives and ensuring confidentiality; however, I never received a response. Although I was unable to interview a professional in either clinic, these instances reminded me of how my affiliation with McGill could both facilitate my research and also obstruct it.

THE DESIRE TO PLEASE

In interviews with international medical professionals, I quickly learned how they viewed my research as being beneficial to their clinics. They often saw my research as helping to dispel beliefs about the potential dangers of fertility travel. Although I repeatedly reminded them that their clinics could not be named in the study, I had a sense that the overall feeling was that they felt that this data could be used to help attract patients to their clinics. They often highlighted their success rates and low costs of treatment, pointing to advances their clinics had made. In doing so, they provided me with data on how they attempted to attract participants. In one instance, a doctor even suggested a potential business partnership between me and his clinic. I quickly turned down his offer and reminded him that I was a doctoral student conducting research. These remarks also reminded me that their responses may be filtered to present the best image of their clinic.

Despite the importance that most of the international medical professionals placed on this positive image, I was able to uncover some dissatisfactions and opinions of medical professionals who did not paint an entirely rosy picture of their clinics. These more critical perspectives often came out in longer meetings. That is, the more time that I spent with an individual, talking to them, the more I felt like I was capturing a holistic view of their clinic. These instances of prolonged exposure were most common in the Czech Republic as often I was picked-up from train stations, offered tours of the clinics and talked with multiple fertility staff. It was in these moments, when I was offered lunch, a cappuccino and/or water, that I realized that the staff were making a concerted effort to please my tastes, just as they would a paying recipient/client. For example, not only was I often offered free transportation from the local train station, but they often provided me with information on how I could stay at an affiliated hotel with a discount. In the course of my research, I did not choose to stay at an affiliated hotel both because these hotels were beyond the budget of my study and also because I wanted to maintain some distance from the clinic. Speier (2016) in her ethnography of one fertility clinic in the Czech Republic did stay at the pension attached to the clinic talking with patients in the lobby to become intimately acquainted with the workings of the clinic.

LANGUAGE AS A BARRIER AND FACILITATOR

As stated in the methods chapter, I conducted all of the interviews with the international fertility medical professionals in English to better capture how these professionals were able to communicate with potential recipients. For individuals that I interviewed whose first language was not English, they all apologized profusely for making grammatical mistakes. Some even seemed embarrassed that their English was not "perfect." I attempted to reassure them that their English was much better than my Czech or Spanish, but their efforts to speak fluently and without mistakes both engendered in me a sense of discomfort, as I was not able to converse with them in their native language, and also allowed me to see the efforts they made to communicate clearly with their English-speaking patients. In the interviews that I did with fertility specialists who were from the UK living in Spain (n=2), I noticed how they emphasized their similarities to the participants that they were treating based on sharing a similar native language and how in turn they spoke more confidently with me.

INTERVIEWING ELITES

While medical professionals in the Czech Republic and in Spain were generally extremely hospitable, often going out of their way to ensure that I was able to talk to someone at the clinic, the recruitment process in Canada was much more challenging. While there were a couple of exceptions, in most instances the fertility medical professionals and lawyers made me feel (and often times made it known) that they were doing me a favor. I was often left in waiting rooms or made to reschedule the interview to accommodate their busy schedules. While I appreciated the time that each of these busy professionals spent with me, I realized that their schedules would also limit the data that I was able to collect. In order to adapt to their hurried schedules, I made sure that the interviews were thirty to forty-five minutes so that physicians and lawyers would be more willing to speak with me. However, at the time of the interview, I was often able to speak to the respondent for more time than was previously scheduled. Adapting to the professionals' time constraints became a way that I was still able to collect data.

Appendix E Reflections on positionality

For all of the fertility professionals, I was interviewing elites. Mikecz (2012) and Harvey (2011) suggest some guidelines for cultivating trust among fertility professionals, including gaining knowledge about the respondent and their work. At first, I followed these guidelines; reading-up on the clinic and the types of egg donation that was offered at the clinic so that I would be able to converse more easily with the interviewee. However, while interviewing physicians, I quickly realized that admitting my knowledge of the procedure or the type of donation that existed at the clinic, the physicians would feel as if they had nothing to talk about. Therefore, I often did not divulge how much I knew about egg donation with these medical professionals. Instead, I allowed them to "teach me" as it allowed me to gain more detailed information.

Although physicians often divulged more information about their practices, if I acted more like a student, counselors and lawyers often became irritated if I stumbled over the exact wording of the law or didn't fully understand their practices. Therefore, in these interviews, I kept notes in front of me that detailed the exact language of the law to prevent repeated corrections. I found the lawyer interviews the most difficult because they were both very concerned with language that I used and also were reluctant to provide me with their own opinions. In order to understandings of the law, I often asked them the same question in multiple ways to see how their answers remained the same or changed.

While none of the fertility lawyers or fertility physicians offered to pass on my information to their clients, counselors often agreed to take my study flyers to put in their waiting rooms or post on their websites. The fertility lawyers and physicians refused to do this as they believed that it would be breaking confidentiality, even though I only asked for a space to place my recruitment information. The inability to recruit fertility patients at fertility clinics limited the ways that I could find fertility patients and prevented me from talking with fertility patients who were making the decision to use donation but had not yet taken steps to pursue it. My inability to gain access to fertility clinics may have been due to my lack of status. On another project that I worked on during my time at McGill, the research team was able to gain access to four reproductive health clinics and recruit patients in their waiting rooms. This access was largely predicated on the primary investigator's network and her ability to get fertility clinicians on board with the research and attach their names to the grant and subsequent publications. My inability to recruit at fertility clinics may have been because of my inability to provide these physicians with a tangible benefit to their careers as well as the possible implications of my work.

TAKING TIME

My recruitment of fertility patients was largely done online and was dependent on forums and support groups' moderators. In one case, I was lucky to create a connection with an online and in-person support group. This support group provided me with four respondents. I am cognizant that this method of recruitment may have biased my data as individuals may have come from the same fertility clinic. However, I did not notice major differences between these four women's experiences and that of other women I recruited online.

Most of the women who spoke with me gave-up their evenings or Saturday mornings to recount their stories. They often told me that they were participating to help a graduate student, having they themselves been in my situation or seeing a friend or family member try to find participants for a research study. A few of these women also saw their participation as a way to advocate against the *AHRA:* most of the women just wanted more information about the process of egg donation in Canada to exist. I see this dissertation as a first step in recounting their stories.

However, I hope to develop more patient-centered materials in the future that illustrate the ways in which these women pursued a family to share with future fertility patients in need of egg donation.

I found the interviews with fertility patients emotionally draining as most women had spent several years in fertility treatment and often received inadequate care. There were often brief pauses in the interviews as the participant cried. Some women told me that this was the first time that they had thought about their fertility treatment since their child was born or since their decision to stop treatment. Although many of these conversations were difficult, baby cries often interrupted the interview, which for these women was a reminder of the worthwhileness of their journeys. These interruptions to the narrative made me realize how these women valued motherhood in spite of their difficult journeys.

ANXIOUS REPRODUCTION

Although I often sympathized with the women and their struggles to build a family, it was often difficult for me to relate entirely to their experiences and desire to have a child. Although I have my own risk factors for infertility, I have not attempted to conceive, pursued fertility treatment or seriously considered having a child. These interviews did instill in me a sense of precariousness in my own fertility and I often found myself obsessing over the age at which I *should* have a baby, if I were to decide to have one. I had to be mindful not to turn these obsessions into judgments of these women who were often having children later in life. That is, I frequently had to remind myself that these women's "choices" to have a child later in life was a result of structural factors that made it difficult for women to have children earlier.

During the course of this research, I was forced to confront how my own choices to pursue a graduate education and delay childbearing may make it more challenging for me to conceive later in life. Physicians often asked me my age and told to freeze my eggs or begin to have children. These words of advice made me uncomfortable as my own reproductive choices were critiqued. At the same time, these comments also gave me insight into how the women respondents in my sample may have felt in conversations with their physicians, friends and/or family members who may have implicitly or directly blamed them for their own infertility. Thus, my own experiences, of “fertility policing”, made me attentive to the ways in which these women may have felt that their previous choices to delay childbearing caused their infertility. Although this dissertation does not explicitly examine these feelings of blame, I hope to explore this topic further in another iteration of my work.

While my positionality may have affected the ways in which I collected and analyzed my data, the results that I illuminate here are presented only upon intense reflection and conversations with many others. I acknowledge that my predilection towards Marxist feminist theory and potentially my experience as a white American living in Canada may have led me to see the process of egg donation as work and labour. Others may bring different perspectives to this data or collect new data of their own. However, in the spirit of building academic knowledge that can be critiqued and built-off of (Longino 1990), I present these stories as empirical data. It is my hope that this data will be the starting point for a better understanding of the intersections between public policies, assisted reproductive technologies, reproductive labour and motherhood in the context of the Canadian egg donation market.