

**New Reproductive Assemblages:
Understanding, Managing and 'Using'
Human In Vitro Fertilization (IVF)**

Edyta Magdalena Just

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Nieuwe Reproductieve Assemblages:
Begrijpen, Beheren en 'Gebruiken' van Menselijke
In-vitrofertilisatie (IVF)
(met een samenvatting in het Nederlands)

Proefschrift

ter verkrijging van de graad van doctor aan de Universiteit Utrecht op gezag van de
rector magnificus, prof.dr. J.C. Stoof, ingevolge het besluit van het college voor
promoties in het openbaar te verdedigen
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door

EDYTA MAGDALENA JUST

geboren op 15 december 1977
te Lodz, Polen

Promotoren: Prof.dr. R. Braidotti

: Prof.dr. R. Buikema

For my Parents Teresa and Marian Just
Moim Rodzicom Teresie i Marianowi Just

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Sometimes, especially in the autumn, there are days when the sky almost touches heads. The clouds arrange themselves in amazing configurations, gliding majestically, swollen with rain. The wind sweeps through their futuristic shapes adding to the wonders of the cloud-cap gallery. The whole scene is as threatening as promising. There is a feeling that something is just about to happen. One may simply anticipate a heavy rainfall or one may expect something unpredictable, something magical, almost supernatural to occur. In those days a couple of years ago, I used to have a feeling that the clouds, in a passionate dance with the wind, would suddenly form a secrete passage to other yet unknown spaces, which would have had as much to do with different geo-political locations as with the other version of myself, the transformed and uploaded space of my very body/subjectivity and the space of creation and production. Someone said "*Be careful what you are wishing for*" I was and I do not regret that one day I spotted the gates beyond which the new geographical co-ordinates were awaiting me and beyond which my very metamorphosis and challenging creation could have begun. The years I have spent writing my dissertation at Utrecht University have been precisely all about those new spaces I was once so eager to explore and become. Every exploration and every becoming is a challenge without proper maps, good equipment or affirmative and positive guides-friends who may appear with a box of matches when a spark to set the fire anew is needed. My journey through the PhD roads when I have been trying to remain creative, when I have been drawing the contours of my life in Utrecht and transforming my very own shapes has been full of delivered in time maps and equipment of the supreme quality. More importantly, however, it has been populated with the sorts of guides-friends one may truly wish for whenever new landscapes of any kind are entered or formed. It is impossible to distinguish between exploration of landscapes and becoming landscapes as those two are tightly interconnected. Similarly, it is also difficult to say who has accompanied me during this exploration and who has added significantly to my very own singular metamorphosis. It is also a challenge to express my true gratitude to all those who have come with the box of matches and even if sometimes the box was wet it still has mattered so much to me. Despite the infirmity of my memory banks and the caducity of the affects stored there, I will try to express my true gratitude to all those who in one way or another have turned my traveling into this unforgettable occurrence.

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INTRODUCTION

For the past few years, human beings have had the ability to trigger a new life in bedrooms (or for that matter any other convenient places) as well as in special laboratories. When the latter is chosen then the reproduction is referred to as assisted reproduction. Human in vitro fertilization (IVF) is precisely what one may call assisted reproduction or technologically enhanced reproduction. What one may observe is the creation and proliferation of, what I call, 'new reproductive assemblages'. The 'new reproductive assemblages' are the spaces where constant interactions between women/bodies and men/bodies take place as well as between them, fertility doctors and advanced reproductive techniques/practices. There have been many debates, discussions and publications, especially from the feminist' point of view, that have critically addressed the phenomena of human reproduction, human bodies, 'reproductive' (female) and 'productive' (male) bodies, issues of fertility and infertility, new reproductive technologies, the power of existing ideologies, cultural and social norms, beliefs and discourses. These topics are broad and discussion is certainly not finished yet. In my opinion, much still needs to be said about these issues, especially when it comes to prolonging/generating life. I want to contribute to the ongoing discussion regarding bodies and, so to say, the 'reproductive-productive-fertile-infertile-technologically-marked matrix'. As such, I want to address issues of female and male (reproductive-productive-fertile-infertile) bodies and sexualities. I also want to challenge the understanding of in vitro, to talk about the best ways of managing it, but also about using the phenomenon to transform existing ideologies, cultural and social norms, beliefs and discourses concerning the matters of reproduction, fertility-infertility, female and male bodies and sexualities, as well as, the advanced reproductive technologies themselves. In order to address female and male (reproductive-productive-fertile-infertile) bodies and sexualities, to try to understand in vitro, to talk about the best ways of managing and using the phenomenon this dissertation will 'become' the following:

It will 'become' a polemic with both the radical feminists and the Vatican, the head of the Roman Catholic Church, over human assisted reproduction, and to be more

precise over human in vitro fertilization (IVF). The idea to have this polemic also results from the following factors.

First, as Jose van Dijk makes clear, “(...) *objections towards IVF in the first stage came mostly from religious side*” but soon “*between 1984 and 1987 particularly feminist voices galvanized the discussion*” (1995:87). This situation, however, is not surprising. For the Vatican, the human in vitro fertilization (IVF) technique interferes with the holy realm of reproduction thus in the origins of every human being, a theme that has always been at the centre of religious groups, as the discussion about anti-conception and abortion illustrates. For the feminists, the main concerns focus on the risk of reducing women to potential mothers, making them responsible for procreation and burdening them with heavy and risky medical treatment.

To concentrate exclusively on the Vatican's discussion over IVF is due to four important factors. Firstly, there has been a long history of the Vatican's involvement and interference in scientific development. Secondly, the Vatican stands for a big publisher with an enormous number of issued letters, declarations and other documents referring to and commenting on all the aspects of human existence. Thus, with an increase in fertility problems accompanied by the spread of technological assistance in reproduction, the Vatican has once more presented its position on the matter. Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation Replies to Certain Questions of the Day known as Donum Vitae given by the Congregation of the Doctrine of the Faith in February 22, 1987 in Rome, approved and ordered to be published by the Supreme Pontiff John Paul II, appears to contain the Vatican's complete statement on technological assistance in human reproduction, including IVF technique. Donum Vitae (1987) completely discards and rejects such a manner of conceiving a child. The third factor that has made me focus on the Vatican's discussion over IVF has to do with the fact that Catholics account for 17, 4% of the world's population (Kington 2008). This number, (I would argue,) gives valid reason to presume with relative assurance that the (possible) impact of the Catholic doctrine may be relatively high. Finally, the decision to focus on the Vatican, is conditioned by the fact that religion, to quote Bryan S. Turner, plays a very significant role in “*management of human embodiment*” meaning the

disciplining and controlling the “*management of the body and populations*” (1991:19).

As far as the feminists’ debates over IVF are concerned, what must be kept in mind is the high variety of the responses issued toward invention and practice of reproductive technologies, including IVF. Yet, as previously quoted van Dijk observes, “*Between 1984 and 1987, feminists acquired the public image of being radically opposed to all reproductive technologies. The most vocal group of feminist indeed perceived of IVF and similar techniques as a direct threat to women’s reproductive freedom*” (1995:89). In 1984 at a conference in Groningen, the most radically opposed feminists founded the Feminist International Network on New Reproductive Technologies later changed to Feminist International Network on Resistance to Reproductive and Genetic Engineering known as FINRRAGE. This was done in order to create “*an organized discussion platform*” whose members “*actively started campaigning against the implementation of all new reproductive technologies, because they considered them to be an unequivocal threat to the lives and rights of women*” (Van Dijk 1995:90). The very radical voices such as those of Gena Corea, Renate Duelli Klein, Jalna Hanmer, Barbara Katz Rothman or Robyn Rowland were the first to be the most widely articulated within the feminist groups although, as indicated before, not the only ones. Because, those feminists have produced very radical opposition toward IVF I have decided to concentrate on their debate at the same time referring to its authors as the radical feminists.

Secondly, the idea to have a polemic with the radical feminists and the Vatican over IVF is conditioned by the fact that those two radical positions have a lot in common when assessing this method of conception. This, at first, may sound a bit paradoxical since for the radical feminists this technique is sometimes thought about as being aimed at the maintenance of heterosexual families and at strengthening notions of motherhood whereas for the Vatican, the same technique is assessed as a threat and a danger to the existence of those very families. Yet, I am not alone in recognizing their similarities. Paul Lauritzen notices them as well when he points out that “*(...) as surprising as it may seem, Vatican opposition to reproductive technology complements the resistance to assisted reproduction found in some feminist writings,*

particularly those associated with the Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE)” (1993:5). All in all, IVF technique (the radical feminists and the Vatican) and IVF practice (the radical feminists) are evaluated as responsible for control, surveillance, objectification and commodification of the human body and reproduction. In addition, it is also said that IVF technique has become synonymous with a miracle technique that is truly successful, easily performed and very well supervised when in fact the ‘reality’ is believed to look ‘slightly’ different. For both, the radical feminists and the Vatican, the human body constitutes the major issue of concern. The radical feminists write about the fragmented and disassembled female body in assisted reproduction. The Vatican, who focuses also on the bodies of men and of prospective children, emphasizes their reduction, control and objectification caused by IVF technique.

Thirdly, in my opinion, the radical feminists’ and the Vatican’s assessment and conceptualization of, but also their approach towards IVF technique and IVF practice do not qualify as accurate. What is more, from my perspective, their inaccurate and negative (thus unbalanced) evaluation/conceptualization of and approach to IVF technique and practice result from the theories (used to negotiate/debate in vitro) and manners of discussing IVF. Yet, the group (the radical feminists) and the institution (the Roman Catholic Church) do have the potential to create and influence existing and circulating notions regarding this new method of conception and its practice (Paul Lauritzen, 1993; Bernard M. Dickens, 2001; Jana Sawicki, 1991; Janet Gallagher, 1987; Michelle Stanworth, 1987). At the same time, they may have an impact on public opinion concerning assisted reproduction, the infertile couples’ negotiations and decisions but also on the ways IVF technique is organized and performed (Paul Lauritzen, 1993; Bernard M. Dickens, 2001; Raport Niepłodność, 2005 (Infertility Report, 2005)). Such influence is possible because, among other things, human conception has always been approached in terms of a sacrum “(…) *the conception and birth of children has customarily been regarded as a private or family matter, regulated by the unpredictable chance of nature or as a divine mystery outside decisive human control. The principles of family law within a community reflect its most historical and customary or intuitive values, often embedded in religious beliefs regarding private intimacy, associated with the transition between*

generations of family traditions, identity and property” (Dickens 2001:337). Changing public opinion and modifying believed in norms and ideas usually take a considerable amount of time. Unfortunately, the societies, where the religion plays important role, are not very prone to metamorphoses and transformations “*Societies progress through this transition at different paces, and establish and change their policies accordingly. Those most influenced by religious concepts are in some ways slowest to progress*” (Dickens 2001:337). Additionally, it should be remembered that the Catholic document, I refer to, was signed by Prefect Joseph Cardinal Ratzinger, who in 2005 was selected as the Pope. This fact may easily work as an indication that the position taken by the Vatican on assisted reproduction, IVF including, is not going to be changed in the near future. As I have suggested, the doctrine of the Catholic Church may have a real impact on prospective parents’ negotiations, social attitudes towards IVF technique/practice but also on the legal arrangements concerning those issues. Therefore, it may indirectly influence the conditions of the ‘parental becoming’ for all who opt for technological assistance in conception. Even if, as van Dijk suggests, the general discussion has become a very eclectic one, the radical feminists’ and the Vatican’s position on IVF and its practice still remain well preserved and have an impact on current developing discourses. As their evaluation is very negative, the impact they may possibly have can equally be very negative. At the same time, because the assessment and approach to IVF and its practice both lack positive notes, it makes it impossible for any changes or improvements to be proposed and introduced. Jana Sawicki writes, “*Analyses that simply reject new reproductive technologies do not assist women in making choices. Nor they lead to creative political strategies*” (1991:92). Yet, it appears that these techniques and practices are both here to stay. Therefore, the need for a polemic with the radical feminists and the Vatican seems to be pressing, urgent and certainly justifiable.

In Part I of Chapter One I will describe the discussion of the radical feminists on IVF technique and practice (organization and performance) and of the Vatican on IVF technique. To present the feminists’ debate(s) on this new conceptive technique and its practice I will refer to the following publications: Man-Made Women. How New Reproductive Technologies Affect Women (Corea ed 1985), The Mother Machine. Reproductive Technologies from Artificial Insemination to Artificial Wombs (Corea

1986), Test-Tube Women. What Future for Motherhood? (Arditti, Duelli Klein and Minden eds 1984). To discuss the Vatican's debate on IVF technique I will focus on Donum Vitae (1987). In Part II, I will concentrate on the theories and manners of discussing human in vitro fertilization employed by both radical feminists and the Vatican, and argue that because of these theories and discussions the assessment of, conceptualization of and approach to IVF technique and IVF practice become negative and inaccurate. In Part I of Chapter Three, Four and Five I will try to prove that theories and manners of discussing IVF other than those characteristic for the Vatican and the radical feminists, can result in a much more accurate and possibly much less negative evaluation of, conceptualizations of and approaches to IVF technique and its practice. Therefore, I will propose a theoretical answer to ethical and practical problems (IVF). The theories I will refer to in Part I of Chapter Four and Five address the human subject and the human body and have been proposed by scholars such as: Rosi Braidotti, Gilles Deleuze, Claire Colebrook, Elizabeth Grosz and Hannah Arendt. The manners of discussing IVF stand for my own suggestions yet certain ways of debating this phenomenon, which I will propose (in Part I of Chapter Three, Four and Five) are based on the suggestions given by Ann Rudinow Saetnan and, again, on Gilles Deleuze's theories. To show that other evaluation/conceptualizations/approaches are possible when theories and manners are changed, I will firstly prove that the proposed theories and suggested ways of discussing in vitro do find their, so to speak, 'reflection' in 'reality'. In order to do this I will present (in Part I of Chapter Three, Four and Five) what may happen before and after IVF is in motion, functioning of IVF technique and practice at the country level and in the particular clinics, certain pitfalls in their functioning but also what it means to be in a 'reproductive age', to face fertility problems, to start fertility 'treatment' and to go through IVF for both women and men. To present the above mentioned, I will refer to the data gathered from the interviews with the doctors from the fertility centres and the ethicist, the analysis of the fertility centres' web pages and booklets, the analysis of the documents regarding human in vitro fertilization and from the interviews with the couples who participated in IVF.

Furthermore, this thesis will 'become' a proposition for adequate and balanced assessment of, conceptualizations of and approaches to human in vitro fertilization technique and practice.

The invention and organization/performance (practice) of new reproductive technologies, among them IVF technique and practice, are a significant 'visiting-card' of contemporary medicine. It is not surprising that the gradual growth in the use of reproductive techniques such as IVF have triggered many debates and discussion because, as Stanworth argues, "(...) *they crystallize issues at the heart of contemporary controversies over sexuality, parenthood, reproduction and the family (...)*" (1987:18). In a similar vein, Sarah Franklin writes that, "*With the birth of Louise Brown also came into being a new kind of public debate about conception, in which unprecedented procreative possibilities raised moral uncertainty and political controversy. Both the moral issues and the political implications remain controversial today*" (1995:1). Jose van Dijk points out that the recent debate over reproductive technologies "(...) *becomes less polarized in terms of ethical, religious or feminist opposition*" and that "*oppositional voices seem to vanish*" yet she also admits that "*they are just harder to identify*" as "*feminist critics strategically move towards the mainstream public debate, and dominant voices move to absorb criticism previously launched by feminists*" (1995:121). Nowadays, the 'voices' discussing IVF technique and practice are certainly highly diversified and quite often truly antagonistic. Thus, no consensus as far as IVF is concerned exists. Yet, in my opinion, consensus is not really needed. Most important is that the acknowledgement of the invention and existence of IVF technique and its practice should lead neither to its immediate rejection and condemnation nor to its uncritical admiration. Extreme positions are not good. Rosi Braidotti stresses that, "(...) *an in-between positions need to be opened up, neither technophobic, nor naively technophilic, but rather sober enough to address the complexities engendered by our historicity; (...)*" (2002:147). Therefore, it is crucial to come up with adequate assessment of and approaches to, but also conceptualizations of IVF technique and its practice. Assessment, approaches and concepts that are not all together dismissive or uncritically admiring but balanced.

These are essential as IVF technique and its practice are not about to disappear. On the contrary, their further increase in implementation can be anticipated. One reason for this is mostly due to the fact that fertility problems have recently become addressed in terms of a 'plague'. Nowadays, infertility stands for a real and constantly growing medical-social challenge and an undoubtedly 'painful' experience. World Health Organization and United Nations confirm the scale of this situation saying, *"Infertility itself is not a disease, and alone it does not impair medical health, although among those who want to have their own genetically related children it may impair their health in so far as the World Health Organization recognizes "health" as a state not only of physical well-being but also of mental and social well-being. On this basis UN conferences have endorsed the definition that: "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have ... the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have ... the right of access to appropriate health-care services that will ... provide couples with the best chance of having a healthy infant."* Infertility can deny mental or social well-being and be a cause of acute affliction and anguish, evidenced by the extent of physical and financial cost individuals are willing to bear for its relief" (Dickens 2001:335).

With the increasing fertility problems among the population combined with the development and growing use of IVF tech, it can be assumed that given the opportunity, those desiring offspring would most probably consider this option. The authors of Cyborg Babies suggest *"(...) if it can be done, it must be tried (...) if it can be tried, then I must try it. In other words, the existence of new reproductive technologies (NRTs) opens up new potentials for reproduction: once they are open, because they exist, they cannot be ignored"* (Dumit and Davis-Floyd 1998:7).

However, there may be certain pitfalls and dangers existing when it comes to both IVF technique and IVF practice. Thus, again, accurate and balanced assessment, approaches and conceptualizations are truly necessary.

These are also welcomed in many scholarly fields, especially in feminists' circles. This is mainly because of the necessity to assure the best future for feminist politics. Sarah Franklin writes that, "*Feminist have been troubled and divided by a score of new reproductive dilemmas*" thus "(...) *feminists need to develop new approaches to these politics*" as there is "*the consequent need for a redefined feminist engagement with it*" (1995:2). Similarly, Haraway, quoted by Braidotti, emphasizes that, "(...) *our techno-world being what it is, the future of feminist politics will depend to a large extent on how women negotiate the transition to high-tech motherhood*" (1994:109). Assessment, adequate and balanced conceptualizations and approaches are also important because as Braidotti stresses, "*Many feminist theoreticians are (...) [already]¹ concerned by the gap that these technologies open between "real" women-and particularly "sterile" women who seek biomedical help to reproduce-and the feminists who criticize biotechnologies*" (1994:108).

In Part I of Chapter Three, Four and Five when proving that the other theories and manners of discussing IVF than those characteristic for the Vatican and the radical feminists can result in much more accurate and possibly less negative evaluation of, concepts of and approaches to human in vitro fertilization, I will propose and deliver some adequate and balanced assessment/concepts/approaches to IVF technique/practice.

Furthermore, this dissertation will 'become' a proposal of particular recommendations for the Vatican, the radical feminists, feminists and those involved in men's studies regarding how to 'go about' IVF technique and practice. I will recommend the best, in my opinion, ways of managing in vitro. My thesis will also include certain suggestions regarding theory of desire, feminist and men's studies theories. I will suggest theories 'based on IVF' that can be used to transform existing ideologies, cultural and social norms, beliefs and discourses concerning the matters of reproduction, fertility-infertility, female and male bodies and sexualities, as well as the advanced technologies themselves.

¹ Emphasis added.

The reason for doing so is, as indicated before, mostly because certain groups and institutions do have an influence and impact on people's negotiations of and attitudes towards both fertility issues and assisted reproduction but also the ways, in which assisted procreation is arranged, organized and performed. It is also because those technologies are not about to disappear and fertility problems are not about to vanish overnight either. It is reasonable to recommend and then undertake certain actions and/or to suggest and have particular theories as eventually they (actions, theories) can be of help to women and men 'being in reproductive age', those facing problems with fertility and those, who will decide to participate in assisted reproduction such as human in vitro technique/practice.

As such in Part I of Chapter Three, Four and Five I will describe how abusive IVF technique and practice may become when the Vatican negatively assesses and rejects reproductive technologies but also emphasizes that "*Civil law cannot grant approval to techniques of artificial procreation (...)*" (Donum Vitae 1987). I will point out how difficult it could be to be infertile, to commence fertility 'treatment' and to go through IVF (technique and practice) for both women and men when the Vatican condemns and calls for a non-approval of IVF. I will explain and present what I consider to be the 'relatively optimal' way of functioning of IVF technique and practice (that I support) and show what it means to commence fertility 'treatment', to go through IVF for women and men when its functioning is, as I see it, the 'relatively optimal' one. Then, in Part II of Chapter Three, Four and Five I will present that the proposed theories and manners of discussing in vitro, the more accurate and balanced evaluation of, concepts of and approaches to IVF but also all descriptions² result in important suggestions regarding theory of desire, feminist theory and men's studies theory, and have their outcome in certain recommendations for the Vatican, feminists, the radical feminists and those dealing with men's studies concerning how to 'go about' IVF technique and practice. I will also try to indicate the possibly

² The description of how abusive IVF technique and practice may become and how difficult for some is to commence fertility 'treatment' and to go through IVF (technique and practice) when the Vatican negatively assesses, condemns and calls for a non-approval of IVF; of the 'relatively optimal' ways of functioning of IVF technique and practice; of what it means to commence and go through IVF for women and men when its functioning is the 'relatively optimal'; of what may happen before IVF is at stake; of the functioning of IVF technique and practice at the country level and in the particular clinics and of certain pitfalls that can be mapped out in their functioning; of what it means to be in a 'reproductive age', to face fertility problems, to start fertility 'treatment' and to go through IVF for both women and men.

positive outcomes of the proposed recommendations and suggested theories for all who found themselves in a ‘not-always-easy-to-be-in-reproductive(?)’-matrix’.

In order to present the Vatican’s impact and the ‘relatively optimal’ ways of functioning of IVF, I will refer to the relevant empirical material. I have already mentioned the way I have collected the necessary data but I will repeat it once more here; this time I will be more specific. The data I am going to refer to was gathered from the following: the interviews with: Prof. Bart C.J.M. Fauser, M.D., Ph.D., Gynaecoloog, Hoofd Afdeling Voortplantingsgeneeskunde, Medisch Manager/voorzitter MT, Divisie Perinatologie en Gynaecologie, Afdeling Voortplantingsgeneeskunde (Department Chair of Division Perinatology and Gynaecology at the Department of Reproductive Medicine) in UMC/AZU on April 5, 2005; Carolien Boomsma, AGNIO (Assistant-Geneskundige Niet in Opleiding) member of the in vitro team in Diakonessenhuis, Utrecht, on March 29, 2005; Dr. J.M.D. de Waardt from Ministerie van Volksgezondheid, Welzijn en Sport, Afdeling Ethiek (Ministry of Health, Ethics), 2005; Dr. X.Y. (the name of the doctor was asked to be kept confidential thus it is referred to as X.Y.) in Salve-Medica, Lodz, on 21 May, 2005; Dr. Michal Radwan in Gameta, Lodz, on 18 May, 2005; Dr. Zbigniew Zalewski, the bioethics and philosopher of medicine at the Jaggiellon University, Krakow in July 2005; the analysis of the medical centers’ web pages and leaflets (UMC/AZU, Diakonessenhuis, Salve-Medica, Gameta); the analysis of the Dutch documents referring to in vitro: Zorgverzekeringswet (2006) (The Health Care Insurance Act), Wet donorgegevens kunstmatige bevruchting (2004) (The Donor Act), Embryowet (2002) (The Embryo Act); the in-depth interviews conducted in September/October 2005 and January/February 2006 with twenty-six (in total) Polish and Dutch heterosexual couples. All of the interviewed couples had one or two children conceived through IVF. Due to the request for anonymity expressed by the couples, all the names have been changed. The idea to focus on the Netherlands has to do with the fact that in this country, at least in my opinion, IVF functions in the ‘relatively optimal’ manner. As in Poland the influence of the Vatican and the Polish Catholic Church is still very tangible when it comes to policy making and general mentality regarding IVF I have decided to focus precisely on Poland.

Finally, this dissertation will ‘become’ a critical reading of the visual representations of human in vitro fertilization.

I have said that adequate and balanced assessment/concepts/approaches regarding IVF technique and practice are needed in the scholarly world. However, the citizens should also be able to formulate/have these assessment, conceptualizations and approaches, thus to understand what human in vitro fertilization is ‘about’. At present there are many visual representations referring to human in vitro fertilization. Next to various publications or debates negotiating IVF from different perspectives, the technologically assisted reproduction has been given an additional dimension. More precisely, so to say, a ‘visual matrix’ of human in vitro fertilization has been established adding still more complexity to the already complicated picture. Sarah Franklin refers to that when saying that, “*Not only the print media but the visual media now use a range of reproductive imagery, facilitated by the various scanning, screening, and other imagining technologies (...)*” (1995:325). Nowadays, the visual media play a very significant role in influencing the ways, in which one evaluates, judges and adapts to the surrounding ‘reality’. Visual representations create concepts one may have regarding the life one is immersed in. The shape of public imagery remains under the influence of the images delivered through the visual media. Franklin (2000), while showing the importance of the cinema and movies for creating certain concepts concerning nature and life, emphasizes the power of visual to re-imagine life and life’s creation through the very medium itself. She also argues that, “*(...) the remaking of nature [through visual media such as cinema]³ becomes apparent as cultural process in a manner which defies separation into ‘real’ versus ‘imagined’ life*” (2000:207, 224). The visual representations of human in vitro fertilization do not remain indifferent to the way people think about this particular type of medical procedure, their bodies, and what is expected from them in matters of choice, rights and duties. Jose van Dijk points this out when she stresses that, “*the clinical gaze distributed in culture*” and the way body or pathologies are visualized “*affects and shapes our collective view of the body*” but also significantly “*contributes to our communal concept*” of certain medical treatments (2005:12). Furthermore, the visual media have been granted the status of one of the major

³ Emphasis added

commentators and negotiators of contemporary events and phenomena, including new conceptive techniques/practices such as IVF. Franklin makes this very apparent in referring to Rosalind Petchesky, who says that, “(...) *cultural representations (...) have become key sites of struggle over the meanings through which reproductive politics are defined*” (1995:325). In addition, it is rather difficult to deny that the visual media are in fact ‘everywhere’ and everyone, who is capable of seeing is literally exposed to the visual media and visual representations. Citizens should be able to formulate adequate assessment/concepts/approaches regarding IVF and those to a high level are conditioned by the visual representations delivered by the visual media. The ‘visual’, as already indicated, is capable of establishing certain concepts and influencing human behavior. Therefore it is crucial to critically read/analyze the currently circulating visual representations of human in vitro fertilization. This kind of critical reading is influenced by a feminist tradition (Feminist Visual Studies) that does not allow one to approach visual representations, especially those originating from the medical field, as innocent products, but always indicates the need for critical readings of these representations/images. This involves locating their origin and the interests involved in their creation. Feminist scholarship teaches us, to quote only some, that, “(...) *visualization techniques are central to contemporary formations of power as domination (...)*” that “(...) *the visual regime is dominant, or molar, (...) saturated with power-relations*” (Braidotti 2002:155) and that “*the significant role of images and imagination in the construction of corporeality is one of the prime motivations for cultural critics to analyse and theorize medical imaging*” (van Dijk 2005:13).

In performing my critical reading of contemporary, widely-spread visual representations of in vitro in Part I, I will present which concept of in vitro emerges when it is visually represented. To map out what kind of concept of IVF has been visually established, I decided to concentrate on the visual representations of IVF, which can be found on Internet. The choice to focus on this particular type of medium was based on the realization that nowadays Internet not only stands for, but also is treated and used as, one of the major suppliers of many kinds of information

and as the site of public debates. On the countless number of pages⁴ the idea behind human assisted reproduction tries to be explained and the assistance itself visually represented. Those representations are usually short movies or various photographic images. As the latter are the most common, I chose them for my analysis. In Part II, I will try to find out why certain visual representations and so concepts of IVF have actually been possible to create. In order to do this, feminist's scholarship is of the uppermost importance. Feminists' analyses, particularly those regarding visual technologies, images/representations originated from the medical field and their proliferation in the public sphere, give interesting suggestions concerning the phenomena. Several scholars in this field emphasize the role the medical field has played in delivering particular images/representations of the human body. Others discuss the implications of the application of the medical imaging and media technologies in the medical field and the specificity of the visual techniques *per se*. The feminist texts also point out the fact that medicine has always had something to do with the 'tradition of display'. They also mention that behind every representation there are certain interests, which in case of IVF could be those of making the method acceptable in order to attract the prospective patients. Furthermore, the feminist analyses equally emphasize how power relations are involved in the production of certain representations and that the representations, especially those concerning human reproduction are usually centered around three issues: 1) the phenomenon of reproduction *per se*, 2) the prospective child, not the mother/woman, and 3) the usually gendered interest in the maintenance of heterosexuality (Braidotti 1994, Petchesky 1987, Jordanova 1989, 1995, van Dijk 1995, 2005, Shohat 1998, Stabile 1998, Franklin 1995, Franklin, Lury, Stacey 2000, Cartwright 1999, Martin 1991). Thus, following feminists's suggestions, presenting and referring to the feminist's analysis, addressing the medical field, the application of visual techniques (also prior and during IVF), the functioning of the visual apparatuses, various processes of visualization and their 'effects' but also the process of recording, I will focus on the role and specificity of the medical field and visual technologies. Furthermore, while presenting the application of visual apparatuses I will show the discrepancy between

⁴ To list a few:

<http://www.advancedfertility.com>; <http://www.ivf.net>; http://uuhsc.utah.edu/andrology/photo_gallery.html; http://www.ihr.com/infertility/articles/infertility_photos.html; http://www.infertilitytutorials.com/procedures_members/invitro.cfm#; <http://www.cbv.ns.ca/young/reproduction.htm>; <http://www.scinetphotos.com/webpage.html>; <http://www.stanfordivf.org/index.html>

what really ‘happens’ and what eventually becomes visually represented. To demonstrate the manners in which the visual apparatuses are applied, how they function and what the processes of visualization and recording look like, I will refer to the data gathered during (already mentioned in this [Introduction](#)) interviews with the medical staff but also to the interview with a physicist Dr. A. Palmero Acebedo from Debye Institute, Surfaces, Interfaces and Devices, Utrecht University, The Netherlands. Moreover, knowing about the ‘tradition of display’, being aware of the fact that certain interests are always at stake, I will map out the motives that have enabled proliferations of particular representations. In addition, by referring to the feminist’s theories regarding power relations and, so to say, ‘reproductive’ representations, I will try to find out if the pattern is repeated. I will do this in order to check out if the medical field, the application of visual technologies, the fact that the tests done prior and during IVF are based on visual techniques, the processes of visualization enabled by the visual apparatuses, the way the apparatuses work, the process of recording, various types of interest, power relations and manners of visually addressing reproductive matters have anything to do with currently circulating visual representations and concepts of IVF and thus, to repeat it once more, to understand why those representations and concepts of IVF as described above could have been created. I will also try to answer the question regarding the accuracy of IVF concepts when established by its visual representations and as such to find if the contemporary visual representations are reliable and if the viewers who want to formulate proper assessment/concepts/approaches toward human in vitro fertilization, thus to understand this phenomenon should choose the contemporary visual representations as a way to do so.

To address bodies and sexualities, to try to understand in vitro, to talk about the best ways of managing and using this phenomenon, to have a polemic, to propose the adequate and balanced assessment of, conceptualisations of and approaches to IVF technique/practice, to deliver particular recommendations and suggestions regarding theories mentioned and to do a critical reading of the visual representations of human in vitro fertilization, this dissertation will gradually grow from empirical-textual to empirical-theoretical. The First Chapter will be an analysis of the radical feminists’ and the Vatican’s publications. In the Second Chapter I will focus on the visual

representations of IVF that can be found on Internet and refer to relevant feminist scholarship and interviews. The Third Chapter will be an empirically grounded argument for redefinition and reconceptualization of human in vitro fertilization. In Chapter Four and Five I will turn to the theoretical framework produced by scholars such as Rosi Braidotti, Gilles Deleuze, Claire Colebrook and Elizabeth Grosz and, again, refer to the empirical data in order to bring a theoretical answer to ethical and practical problems (IVF). Furthermore, this dissertation will deliberately transform from more to less linear. This will be done in order to make one of my points clear, which is that only if the vision of subjects/bodies is changed, certain phenomena such as IVF have chances for a much profound comprehension.

Let us now begin the hopefully promising and exciting ‘journey’ through a ‘bodily’ and at the same time ‘reproductive-productive-fertile-infertile-technologically-marked matrix’.

CHAPTER ONE

The Radical Feminists' and the Vatican's Discussion on IVF

PART I

The Radicalized Discourse. The Radical Feminists' Opposition

The feminists who founded the Feminist International Network on New Reproductive Technologies later on changed into Feminist International Network on Resistance to Reproductive and Genetic Engineering (FINRRAGE) evaluate the invention and practice of reproductive technologies, IVF technique and IVF practice included, very negatively. Reproductive technologies become condemned and basically rejected due to them. Women and their bodies are thought to be controlled and explored by men, the inventors and major operators of those new techniques. In Man-Made Women (1985), and more particularly in the chapter titled The Reproductive Brothel, Gena Corea describes the application of reproductive technologies on animals' farms in order to parallel them with the same technological offer made to women. For her the move from the animal enhanced reproduction to the human reproduction must be seen in terms of increased oppression and surveillance over women's reproductive capabilities. For animals, assisted reproduction is used to improve the number and quality of their offspring. Corea assumes the same motivation behind the idea of the human assisted conception. In accordance with radical feminists' ideas regarding women's place in patriarchal society, that is the contemporary society, for Corea women are thought of as having only one aim in life: prolongation of the existence of the human species, thus the more and the fitter the children that are produced, the better. This, not by an accident, stays close to the eugenics ideology Corea mentions while debating new technologies in her other publication The Mother Machine (1986). Furthermore, with the reference made to Andrea Dworkin's presumption that, "*with new reproductive technologies (...) men will be able to apply the brothel model to reproduction*" Corea emphasizes that, "*while sexual prostitutes sell vagina, rectum and mouth, reproductive-prostitutes will sell other body parts: wombs; ovaries; eggs*" (1985:39). Even if the real scenario does not have to be the one of the reproductive brothel, she still stresses that, "*the fact that women are hated in a male – supremacist culture makes it foolish to dismiss Dworkin's vision as unthinkable*" (Corea 1985:39). In Man-Made Women

(1985), as in The Mother Machine (1986), Corea compares assisted reproduction to both brothels and animals' farms where, according to her, the "*brothel model*" has already been applied. By naming and describing the following phases of in vitro fertilization (insemination, superovulation, estrus synchronization, ova recovery, embryo evaluation and embryo transfer) exercised at those farms, Corea echoes the infertility clinics' brochures and their web pages where the same naming/description is used. Hence, she implicitly suggests the similarity existing between such farms and infertility clinics. Therefore, it becomes clear that for Corea women are becoming nothing more than prostitutes and/or animals under severe surveillance when assisted reproduction is at stake. She emphasizes this resemblance when she says, "*It is easy to dismiss the fate of animals as one entirely different from that of women. However, I do not believe women and animals inhabit such vastly different categories in a male supremacist world*" (Corea 1985:42). Women, when technologically assisted, seem to be turned into passive victims unable to issue any objections and possessing little power to decide their fate. They appear to become helpless marionettes whose strings are kept in the hands of the male scientists and doctors, the inventors and operators of these new techniques such as IVF.

Yet, as Renate Duelli Klein (1985) in the same volume points out, women often choose technological assistance even if it is *per se* oppressive. For her it is due to the lack of adequate knowledge and the impossibility of the critical thinking. She puts it in the following manner, "*(...) sometimes women (...) collude as because we have been brainwashed. The information and education we get is one-sided and male-centered and the hidden conviction creeps into our own minds that men and their technology must be better than our own body and our own experience with it*" (Duelli Klein 1985:69). Previously mentioned Dion Farquar refers to such an attitude in terms of a "*false consciousness*" that has been evoked by the fundamentalist's position which has striven "*to explain middle-class (mostly) white women's escalating demand for infertility services (...)*" (Farguhar 1996:216). Women opting for and participating in assisted reproduction are envisioned as robots, well programmed machines oriented at constant production with assigned places in the "*assembly-line*". The production metaphor truly resemblances the Marxist's approach and as such makes the fact of the anticipated oppression visible. Thus

control and oppression become the key words when reproductive technologies are assessed. Klein emphasizes that saying, “(...) *the ‘new’ technologies (...) reinforce the degradation and oppression of women to an unprecedentedly horrifying degree. They reduce women to living laboratories: to ‘test-tube women’*”, “*an incubator; a vessel; a reproductive body*” (Duelli Klein 1985:65, 66).

Reproductive female bodies are talked about as passive and wide open for the active scientists and doctors to operate on them. As a surface for experimentation, those bodies become not only victimized, but at the same time, are made to lose their status of wholeness. Sticking to the brothel metaphor, Corea describes the succeeding phases (characteristic for assisted reproduction) women are asked to go through as following: “(...) *1 getting the eggs; 2 manipulating them; 3 transferring embryos*” (Corea 1985:45). Commenting in a detail on each of them, she makes it obvious that the control directed at women is directed at their reproductive capabilities, but more accurately at their reproductive body parts. For Corea, reproductive techniques reduce and divide female bodies into fragments as they focus on “*bits and pieces of women*” (Corea 1985:47).

Klein makes this even more explicit emphasizing that, “*The new aspect of the new reproductive technologies is that now it is parts of women which are used – and abused – to control the reproduction of the human species. The technodocs have embarked on dissecting and marketing parts of women’s bodies: eggs, wombs, and embryos. Women are being dismembered – split into separate reproductive parts which can be reassembled, perhaps in a different order, perhaps using parts from different women*” (1985:66). Additionally, when Corea refers to the manipulation of eggs and transfer of embryos, they appear to be what really matters, and thus are given absolutely supreme status when assisted reproduction is at stake. Therefore, reproductive technologies are not only assessed as having a controlling function, but also as a disassembling/dismembering method in which women and their bodies are thought to be suppliers of firstly genetic, and later on, gestational material.

In analyzing this very radical position on assisted reproduction, it appears that neither the method nor the practice can be accepted. Klein describes the method as a “*full*

range of biomedical/technical interferences during the process of procreation (...) that among others “*encompass (...) the full gamut of ‘test-tube’ techniques: in vitro fertilization (e.g. the fertilization of an egg cell with sperm in a glass dish in the lab), embryo replacement, transfer and ‘flushing’, embryo freezing (...)*” (Duelli Klein 1985:64). As far as the practice is concerned, in contrast to Corea, who limits her discussion to the scenario of the reproductive brothel, Klein discusses other manners in which those technologies are organized. According to her, with reproduction “*fully institutionalized as a medical phenomenon*”, women are not well informed about the very method and its possible risks, counseling services are not adequately developed and the medical-technological language is mostly unintelligible (Duelli Klein 1985:67). Similarly, in the same volume, Jalna Hanmer (1985) while referring to the organization of the reproductive techniques, becomes very critical about the processes of admission and access to assisted reproduction. For her the technique and the practice both serve as ways of strengthening the patriarchal system. To support her view, she points out that only women in stable relations with a male partner whose agreement is needed can qualify as legitimate for the ‘treatment’ and that single women or lesbians are usually not admitted at all. She also envisions that the practices of reproductive technologies will add to the already existing inequalities among women in order to actually increase control over them, “*We must assume that women will be divided against each other with some receiving preferential treatment, whatever it proves to be. Possibly there will be fine gradations of differential use as divide and conquer remains one of the best tactics in maintaining control in any exploitative system. A differential response to women is almost certain to occur world wide as well as within national borders*” (Hanmer 1985:97). Women “*divided against each other*” are thought to be more prone to manipulation and surveillance. For her the practice matters to a significant degree and as such she emphasizes the need to challenge “*(...) the way so-called ‘services are organized for women [as due to that it will become possible to challenge] the dominant social interests that lie behind the mobilization of research, funding, and state and public support for present and future developments in reproductive technologies*” (Hanmer 1984:444).

As I have already mentioned, the technology, the very method itself is considered to be of an unacceptable nature. For the radical feminists’ technology, and particularly

reproductive technologies such as IVF technique, are believed to be an “*artificial invasion of the human body*” and to create alliances with them is to give up the human (Duelli Klein 1985:65). Klein emphasizes, “(*...*) *perhaps if women know about the dehumanizing and dangerous aspects of new reproductive technologies we will say ‘no’ to the experts who tries to coerce us, inferring that the technologies are better than our own bodies*” (1985:71). The female body, when made to participate in new reproductive methods, is thought of as losing its subjectivity, becoming merely an object on which to practice and experiment. Additionally, as both Hanmer and Klein suggest, no one is paying attention to the fact that there are real bodies who may suffer and that after all the technological methods can be as dysfunctional as the body it aims to improve. “*The pain, however, is the woman’s problem, whether physical, for instance in laparoscopies (...) or psychological, if again and again hopes for a child are dashed, for the in vitro fertilization success rate is only about 20 per cent of achieved egg fertilizations and about 13-15 per cent of actual births*” (Duelli Klein 1985:67). Yet because of the lack of proper information, brainwashed, passive, reduced and dismembered women’s reproductive bodies continuously opt for the technological enhancement allowing for the removal of “*the last women-centered process*” (Hanmer 1985:96) and for control to be taken away “*from [their]⁵ individual’s body*” and placed “*in the hands of ‘experts’ – the rapidly – and internationally – growing brigade of ‘technodocs’: doctors, scientists and pharmaceutical representatives (most of them male, white, and of Euro-American origin) who fiercely compete with one another on this ‘new frontier’ of scientific discovery and monetary profits*” thus “*closer to being the procreator of the species – playing God – than ever*” (Duelli Klien 1985:65, 66). There is a strong belief that power thus also control are solely male-owned dominium. Kass, quoted by Robyn Rowland in Test-Tube Women. What Future for Motherhood? (1984), makes it explicit writing that, “(*...*) *power rests only metaphorically with human kind, it rests in fact with particular men geneticists, embryologist, obstetricians*” (Rowland 1984:367). Rowland herself appears to agree with such a statement when she stresses that, “*Males run the governments, train the doctors, make birth control devices (...) own the companies who will market the products and make the money. And man will reproduce himself in his own image as he has managed to produce God in his own*

⁵ Emphasis added.

image” (1984:367). As Jalna Hanmer notices, in dominant, patriarchal ideology for women to reproduce and rear children is thought to be a ‘natural’ activity. Even if technology is believed to stand in opposition to a ‘natural’ body it is said to be structured in such a way as to parallel the ‘natural’ reproduction. With the naturalization of new reproductive technologies women are thought to be easier allured by them and thus more willing to opt for technological assistance as merely an alternative to the ‘natural’ processes, which in accordance to the radical position is a totally wrong assumption. As technologies are constructed as ‘natural’ and procreation is a ‘natural’ women’s activity, the more offers of assistance in reproduction, the stronger the notions of compulsory motherhood as a ‘natural’ fact. For women to reproduce is ‘natural; the technology is ‘natural’, thus if nature itself fails, the ‘natural’ techniques will help to preserve what is thought to be ‘natural’. Additionally, in accordance with the radical discourse, technology is constructed as infallible, and the ‘treatment-help’ it offers is talked and thought about in terms of a miracle and perfection. *“Men, through their technology, can perfect embryos, ensure perfect pregnancies and deliveries. Women with only their crude bodies cannot”* (Hanmer 1985:96). With such assessment of technology, which is believed to be enclosed in the hands of men pictured as ‘omnipotent gods’ wanting to *“‘conquer’ another part of life that they have not access to ‘naturally’”*, Klein concludes that *“under [such a]⁶ spell of the ‘technological fix’ – which has solution for every problem”* not to opt for this *“fix”* can easily be judged in terms of stupidity and ignorance: *“A woman’s future and her reproductive fate is all in the experts’ hands – and how could we be so unreasonable as to doubt that it wasn’t all for women’s ‘own good’?”* (Duelli Klein 1985:66, 67). In this sense, reproductive techniques are said to soon become obligatory and mandatory leaving no room for unmediated desires and for other choices to be made.

Yet, as Hanmer (1984) suggests, the invention and functioning of new technologies like IVF are debated in the context of women’s rights to have children and to make their own choices regarding the offer of assistance as a solution to infertility. But to speak about rights to having children, is to speak about compulsory motherhood, which if not realized can only result in stigmatization and pain. At the same time, to

⁶ Emphasis added.

talk about choice is to ignore the fact that within patriarchal society, where these technologies have been invented, *“for the good of individual [unfulfilled]⁷ women”* free choice is rare (Hanmer 1984:438). Referring to the issue of choice Barbara Katz Rothman (1984) emphasizes the importance of sufficient and accurate information in decision-making processes. Yet, as she points out, even if women are supplied with a considerably high amount of information, the resulting choice cannot be expected to be truly free. Similarly to Hanmer, Rothman stresses that it is the very society and social context that really matters as *“The social structure creates needs—the needs for women to be mothers, the needs for small families, the needs for ‘perfect’ children—and creates the technology which enables people to make the needed choices”* all in all *“structures the choices available to individuals”* (Katz Rothman 1984:32, 23). To be able to choose is to gain control and power but attention must always be paid to what is actually underlying each decision. If there are certain points of view circulating in the particular society, to oppose them usually means to expose oneself to negative judgments. Thus, as Rothman writes, even if *“(…) information may expand the opportunity for choices, (…) it certainly does not guarantee whose choices will be honored”* as what really counts *“(…) is power which gives one control over both information and choice”* (Katz Rothman 1985:25, 26). Therefore, the danger especially in the realm of new reproductive technologies, which, as Rothman points out, promise the *“quality control”* of children, is that the choice will become a *“forced”* one. She seems to ask: If a woman is offered the option of having a healthy and fit child, how she can oppose such an option? New technologies, as the radical feminists emphasize, are constructed not only as ‘natural’, miracle-like and quality oriented, but also as the only chance for those experiencing infertility to have an offspring. In contrary to the previously mentioned feminists, who concentrate, mostly on the woman’s position in reproductive technologies, Rothman looks at the issue of infertile couples. She emphasizes that when the option to have a child is given, not to go for it may be evaluated in terms of egoism and selfishness. Therefore, she asserts that consequently those *“(…) new treatments for infertility have also created a new burden of not trying hard enough”* (Katz Rothman 1985:31). All in all, it appears that with the invention of new reproductive technologies, the concept of woman as desiring, active, and capable of negotiating

⁷ Emphasis added.

and making her own choices cannot in any sense be articulated. Therefore, it can be concluded that the aim of these technologies and their organization/performance (practice) seems to be the strengthening of the compulsory-motherhood-structure (as a 'natural' state for all women and the only way to demonstrate their being in the world), the creation of a child, and the maintenance of heterosexuality and the traditional forms of family.

For a long time motherhood has been recognized by feminists as a socially imposed and constructed compulsory state for all women. As Robyn Rowland writes, women *"(...) had children because they were socialized to do so and convinced of the rewards of mothering; in order to gain a self-identity in a world which continually denied this to them; to have a power base from which to negotiate some terms in their lives; to prove their worth and their change of status to that of 'adult'"* (Rowland 1984:357). Therefore, as Hanmer mentions, *"The under – and devaluation of women as people, our valuation only as wives and mothers, makes women vulnerable to social pressures to reproduce and to go through any torture to be able to do so"* (Hanmer 1984:440). Yet, for the radical feminists new conceptive techniques take control over reproduction out of women's hands. As such, they are assessed as in fact destroying the last realm where women can gain and exercise power. As Hanmer writes, to separate *"(...) women from naturalness of conception, pregnancy, and birth by intensifying the control over these processes by a largely male medical and scientific community, undermines women's confidence as biological reproducers of new life"* (Hanmer 1984:445). Simultaneously, it is also stated that to withdraw control over reproduction from the female domain is to actually equate a woman with a man, who lacks the ability to experience reproduction as something continuous (fertilization, pregnancy, birth, childrearing) (Hanmer 1985:94).

For the radical feminists new conceptive techniques affect solely women. They make it clear that even if a man receives technological help, his experience and 'share' in the process cannot be compared to that of a woman. *"Whatever happens to biological reproduction, working-class and any other category of men will not be affected as much as working-class and any category of women. The role of biological*

reproduction is greater, both literally and in terms of the meaning it has for being female or male” (Hanmer 1985:97). The radical feminists also say that a man will never end up as a woman does when assisted reproduction is at stake mostly because “(...) *socially powerful men have class interests with socially non-powerful men*” (Hanmer 1985:98). Therefore, once more, it can be said that even if the radical feminists do oppose the notion of the compulsory motherhood, they in fact use the ‘natural-biological’ rhetoric itself while discussing assisted conception. By emphasizing the importance of biological reproduction as the women’s domain not only the patriarchal rhetoric gets repeated but also it becomes obvious that men will never be made responsible for reproduction. As a consequence, in the radical feminists’ discourse it appears to be impossible for women to ever leave their ‘made-to-reproduce-body’ status. New conceptive techniques are seen as a threat and not in any way a possibility. The moment it becomes suggested by a feminist-- such as Shulamith Firestone (1969)-- that assistance in reproduction can eventually make men responsible for childrearing, the suggestion is immediately discredited. Hanmer seems to agree on many of the same points with O’Brien who sees nothing liberatory for women in new technologies. For O’Brien, women’s oppression arises from the fact that reproduction followed by childrearing is an alienating experience for men. Due to that, feelings of discontinuity are born that can be overcome by the new reproductive methods as in vitro fertilization “*gives absolute certainty in a way that conception via intercourse cannot*” (Hanmer 1985:100). Yet what Hanmer misses is the fact that O’Brien does not continue explaining how such technological mediation may eventually abolish the assumed man’s feelings of alienation and make him truly aware of his participation in reproduction. Hanmer is much more prone to see that men operate new technologies not to conquer the male’s feeling of alienation in order to become ‘equal’ to women, but rather to diminish their own feelings of inferiority (Hanmer 1985:102). In this, Hanmer writes, they find support from the state which directs its control solely at women “*The state directly shapes and supervises the ‘fit mother’ as concept and individual through the personal social services, social security, housing, the health service, education, law and the legal system. Reproductive technology offers the possibility to extend the shaping of the ‘fit mother’ to include the ‘fit reproducer’.* The state is directly involved through its support for, and control of, science and technology. There is no corresponding ‘fit

father' role" (1985:103). Therefore, what is really at stake is "*the extension of 'rights' and power over women as mothers by men, both individually and as a social category*" (Hanmer 1985:104).

Another objection given by the radical feminists' side has to do with the fact that assistance in reproduction is thought of as having solely the 'embryo/fetus/child-to-be' at the center of interest. Furthermore, invention and organization/performance (practice) of reproductive technologies are believed to be aimed at maintaining the traditional, heterosexual form of family: "*(...) the fortress of patriarchal dominance (...)*" as the best environment to be conceived and reared within (Rowland 1984:356). Even if the references made to embryos and fetuses are set in the context of a debate over compulsory motherhood and oppressive technology their presence is still noticeable. In fact, the widely spread male/technological domination exercised in infertility clinics is believed to not only find its meta in the female bodies as embryos are said to share the same fate. Although, without a doubt the fate of an embryo does not form the major preoccupation for either Corea or for Klein, still the fact that they write about genetic manipulation, embryo screening and sex selection resonates distantly a discourse which has at its center critique of the control/objectification of embryos. Thus, it appears, though implicitly, that not only women are thought to be under control, but also their possible prospective children, who may soon be defined in terms of properties, commodities, male doctors' products or better quality/consumer products. However, the screening of embryos will eventually affect no one but women themselves. According to the radical feminists, women will be made obliged to use reproductive technologies not only because they are 'natural', safer, successful and predictable, but mostly because they can produce perfect babies. "*If society selects for totally healthy embryos, it is making a statement that there would be no circumstances under which a "normal" person would choose to bear a child who is not healthy (...)* Women who do make that choice may be viewed as irresponsible or as emotionally unsound" (Corea 1986:91).

In the radical feminist's publications the invention and organization/performance (practice) of the reproductive technologies become completely discredited. Technologically mediated conception as a technique and as a practice is not seen as

engendering anything positive for women. The possible help that the discussed method may offer to those desiring children, or its possible liberatory powers to release women from the burdens of being solely responsible for procreation, are not agreed upon. Overall, these new techniques and their organization/performance (practice) are evaluated as dangerous and threatening, and as such rejected. To sum up, first of all, technology/practice is said to have oppressive and controlling characteristics. Furthermore, reproductive techniques become rejected due to their technological, machine-like thus 'unnatural' features. In addition, new conceptive techniques are assessed as objectifying, dehumanizing, fragmenting and disassembling women and their bodies. What is more, reproductive technologies are said to be affecting solely women. At the same time it is pointed out that invention and organization/performance (practice) of the new conceptive techniques aim at strengthening notions of patriarchy, compulsory motherhood, increasing child production and creating proper, heterosexual families. It is also said that the introduced conceptive technologies are most of the time believed to be miracle-like, superior to the body, predictable, resembling the 'natural' processes, thus the best and the only chance for a successful conception and a healthy, perfect child. This, of course, is not agreed upon. Simultaneously, it is emphasized that information about new techniques is severely limited and that the whole truth about their real nature is not revealed. Finally, assisted conception is made responsible for taking the reproductive power away from the women and their bodies leaving them with no other choice but to opt for and participate in technologically mediated reproduction, invented by (and maintaining) a patriarchal system.

Donum Vitae. The Vatican versus IVF

The Vatican contrary to the radical feminists has heterosexual couples and a 'child-to-be' at the center of its concern. Therefore, when constructing their critique of new reproductive technologies, IVF included, the 'triangle' a woman plus a man plus a child referred to as the basic cell of every society is addressed. In Donum Vitae (1987) there are a number of series of accusations against technological mediation in human reproduction. This particular condemnation of the utilization of highly advanced methods is done thorough the prism of the possible harm it can cause to the partners and a future child. The invention of reproductive technologies is seen as a major factor leading to the destruction, if not the extinction, of the family. Therefore,

when going through Donum Vitae it appears that the term ‘family’ should not be applied to ‘what’ eventually becomes formed due to technological mediation in the human reproductive sphere. Furthermore, it is pointed out that the heterosexual couples who participate in *“illicit practices”*, which for the Vatican means IVF, and children conceived due to it, are inevitably experiencing the loss of the dignity which is intrinsic and granted to all human beings. All in all, reproductive technologies become condemned and rejected, accused of possessing powers that are destructive to families. Thus whoever opts for artificial fertilization will never form and become a family, but will become rather a kind of social formation that stands in opposition to everything the real family is all about. This applies to the heterologous in vitro fertilization defined in Instruction as *“[...] techniques used to obtain a human conception artificially by the usage of gametes coming from at least one donor other than the spouses who are joined in marriage [...]”* but also to homologous fertilization defined as *“[...] the technique used to obtain a human conception through the meeting in vitro of gametes of the spouses joined in marriage [...]”* (Donum Vitae 1987).

In the Vatican’s document it appears that the scientific development is by no means evaluated as wrong and sinful simply by definition. New reproductive techniques are rejected because they are said to possess destructive powers. *“Thanks to the progress of the biological and medical sciences, man has at his disposal ever more effective therapeutic resources; but he can also acquire new powers, with unforeseeable consequences, over human life at its very beginning and in its first stages. Various procedures now make it possible to intervene not only in order to assist but also to dominate the processes of procreation. These techniques can enable man to take in hand his own destiny, but they also expose him to the temptation to go beyond the limits of a reasonable dominion over nature”* (Donum Vitae 1987). As reproductive technologies can grant such powers to scientists and doctors, it is no surprise that they may be seen as dangerous and as possibly generating (currently) unpredictable consequences. Because these new techniques in the field of reproductive medicine act on the level of cells and gametes, going deep into dimensions of life that for centuries have been assessed as sacred, and by doing so actually take over the powers to create life, they must not be approved. For the Vatican the beginning of life, the

human's origins constitute a forbidden territory into which doctors and scientists must not be allowed access. *"No biologist or doctor can reasonably claim, by virtue of his scientific competence, to be able to decide on people's origin and destiny"* as the doctor *"does not have the authority to dispose of them or to decide their fate"* (Donum Vitae 1987). Consequently it becomes strongly emphasized that new techniques *"cannot of themselves show the meaning of existence and of human progress"* (Donum Vitae 1987).

Yet, the Vatican's rejection of reproductive technologies is not based on the fact of their artificiality. *"These interventions are not to be rejected on the grounds that they are artificial. As such, they bear witness to the possibilities of the art of medicine. But they must be given a moral evaluation in reference to the dignity of the human person, who is called to realize his vocation [...] to the gift of love and the gift of life"* (Donum Vitae 1987). From this I can conclude that technology, or any kind of scientific method, which may have an impact on human existence, must be assessed from the moral point of view. Consequently the Vatican, the head of the Roman Catholic Church, recognized as an *"expert in humanity with a mission to serve the civilization of love and life"* and in response to the *"requests of clarification and guidance"* has felt obliged to *"put forward, by virtue of its evangelical mission and apostolic duty, the moral teaching corresponding to the dignity of the person and to his or her integral vocation"* (Donum Vitae 1987). In order to make the proper moral evaluation, the Vatican has taken under consideration particularly chosen criteria. First of all, they emphasize that it must be verified whether the performed technological methods respect the unity of the human being they operate on. Secondly, it is deemed crucial to find out if the applied scientific research or technology is aimed at defending, promoting and confirming *"his [the human being's]⁸ primary and fundamental right to life"* (Donum Vitae 1987). Thirdly, the technological realm must be seen from the perspective of its ability to maintain and support every human's dignity with 'human' defined as *"a person who is endowed with spiritual soul and with moral responsibility"* (Donum Vitae 1987). All in all, according to the Vatican, to get a positive assessment *"science and technology require, for their own intrinsic meaning, an unconditional respect for the*

⁸ Emphasis added.

fundamental criteria [listed above]⁹ of the moral law: that is to say, they must be at the service of the human person, of his inalienable rights and his true and integral good [...] “otherwise they “can only lead to man’s ruin” (Donum Vitae 1987).

In the Roman Catholic Church’s teaching, each person must always be seen “*as a unified totality*”, “*unique singularity*” whose “*nature is at the same time corporeal and spiritual*”, “*constituted not only by [...] spirit, but by [...] body as well*” (Donum Vitae 1987). Therefore, it can be concluded that the, so to speak, body-mind dualism is what the Vatican definitely opposes. As every person stands for the bodily and spiritual entity none can be approached solely in biological terms as body/flesh or in a contrary as having only spiritual/mind characteristics. “*By virtue of its substantial union with a spiritual soul, the human body cannot be considered as a mere complex of tissues, organs and functions, nor can it be evaluated in the same way as the body of animals; rather it is a constitutive part of the person who manifests and expresses himself through it*” (Donum Vitae 1987). Thus it seems essential that the human spiritual nature must always be recognized and its possibility for expressing itself through the body must be secured. With this statement the Vatican appears to situate itself in opposition to the possible reduction of the human body, which may occur when technological assistance in conception is chosen.

As every person is to be seen in its full physical and spiritual dimension, it becomes quite apparent that anything exercised upon the surface of the human entity influences equally these two mentioned levels “*[...] in the body and through the body, one touches the person himself in his concrete reality*” and so it becomes stated that any “*[...] intervention on the human body affects not only the tissues, the organs and their functions but also involves the person himself on different levels*” thus it also “*involves [...] a moral significance and responsibility*” (Donum Vitae 1987). From this quote it is easy to sense the warning that social and cultural realms within which those bodies operate will not remain untouched and unchanged, on the contrary, may actually be severely affected by the utilization of the new techniques.

⁹ Emphasis added.

In the Roman Catholic Church's teaching this particular view of human nature as a "unified totality" finds its realization in the union created between a woman and a man and formalized through the institution of marriage. Thus, the married, heterosexual couple is expected to share not only its physical but also its spiritual dimensions. Sexual intercourse that assumes bodily contact (physical level) between a woman and a man is said to allow love (spiritual level) to be expressed through a body. As such it allows (1) the expression of love *per se* (2) a body to become an expression of love itself. Paul Lauritzen, when commenting on the position of the Vatican, points out that in accordance with the doctrine the unity of the body and spirit can only be maintained when fertilization and conception follow sexual intercourse that gives voice to the partners' mutual love and care "*[...] the personal love is expressed in the language of the body and [...] an act of intercourse that both expresses love and is aimed at procreation unites body and spirit in the bringing into existence of new life*" (Lauritzen 1993:8). Thus when reproduction is moved to the laboratory space, and bodily contact between spouses is not needed in order to conceive, the love itself cannot be actualized through the body. Consequently, by not allowing love to be expressed, technological mediation in reproduction is evaluated as reducing the body to merely its physiological dimension. Lauritzen stresses that if "*[...] procreation is not a product of a loving act that is at once physical and spiritual, it reduces the human body to a mere instrument of the will and opens the door to the treatment of a person as a product*" (1993:8). Moreover "*the transmission of life*" is supported by the Vatican only as an outcome of a "*personal and conscious act*" (Donum Vitae 1987). In consequence, only if procreation follows the suggested pattern, can the dignity of all persons involved (couple and a 'child-to-be') be preserved and protected. At the same time, the inseparability of intercourse and procreation "*the unitive meaning and the procreative meaning*", exclusively belonging to the conjugal union, becomes explicitly stressed "*[...] marriage possesses specific goods and values in its union and in procreation which cannot be linked to those existing in lower forms of life*" (Donum Vitae 1987). The result, as Lauritzen rightly notices becomes that "*[...] intercourse, love, procreation, marriage, and the family belong together. In the Vatican's view procreation is properly undertaken in the context of a loving monogamous marriage through an act of intercourse*" (1993:6). And so the "transmission of life" appears to have a strictly

assigned location; “[...] *the gift of human life must be actualized in marriage through the specific and exclusive acts of husband and wife [...]*” if “[...] *the full sense of mutual self-giving and human procreation in the context of true love*” wants to be realized (Donum Vitae 1987). Thus, the close link between marriage, heterosexuality, love and conception due to reciprocal, sexual intercourse has been drawn. Upon this, the definition of family has been based and constructed. Yet, it is impossible to talk about proper procreation (and so proper formation of family) when partners are literally left aside, and when conception occurs outside the body, outside the marriage and outside the heterosexual relation. If this is the case according to the Vatican, the dignity of those involved cannot be maintained. Such procreation is compared to “*those existing in lower forms of life*” as it can no longer be a space where “*man and woman [may] actualize the fundamental values of love and life*” (Donum Vitae 1987). Additionally, as I have already mentioned, procreation that is performed in the laboratory can only be assessed as purely instrumental and vulnerable to manipulations that can work against the human dignity. Lauritzen, whose point of view is very close to mine, explains the Vatican’s worries very explicitly when he writes that according to the Vatican, “*By allowing for noncoital procreation, reproductive technology diminishes the full significance of human reproduction. It simultaneously turns [...] bodies into mere instruments of [...] wills – thereby dividing us against ourselves – and disembodies procreation in a way that sets the stage for the objectification and commodification of reproduction*” (Lauritzen 1993:6). Thus, as he points out, assisted reproduction is seen as “[...] *dehumanizing because it treats human reproduction as merely material*” (Lauritzen 1993:6).

For the Vatican assisted reproduction does not allow the human being to remain a physical and spiritual entity. By detaching spirit from the bodily sphere, which is what occurs according to the Vatican, the body may become easily objectified and be regarded as mere flesh to operate on. Lauritzen emphasizes, “*The problem with noncoital procreation is that it encourages us to be so focused on [...] desire to have children, i.e., on [...] will to procreate, that we diminish the importance of our bodies in the reproductive process [...]*” and so “*the danger in approaching reproduction in such a dualistic fashion is that it ultimately reduces the person to the*

status of an object” (1993:6). In consequence, as assisted reproduction “[...] separates procreation from intercourse, it bifurcates a person into body and spirit and treats the body either as an obstacle to be overcome or as a mere resource in the service of the spirit” (Lauritzen 1993:6). With technology being made responsible for separating, what may never get separated (and as such for objectification of the human being), the Vatican in the discussed document positions itself against any possible technological mediation in human reproduction. For the facts determining any sort of disconnection between sexual intercourse, love, marriage and procreation must “determine from the moral point of view the meaning and limits of artificial interventions on procreation and on the origin of human life” (Donum Vitae 1987).

The Vatican accepts the inevitable development in science and technology and is not against technology because of its artificiality. The Vatican, however, does oppose technology if it fails to respect human dignity “*Science and technology are valuable resources for man when placed at his service and when they promote his integral development for the benefit of all*” (Donum Vitae 1987). Therefore, “*The medical act must be evaluated not only with reference to its technical dimension but also and above all in relation to its goal which is the good of persons and their bodily and psychological health*” (Donum Vitae 1987). For the Vatican, new technologies can only be judged as disrespectful and harmful to those opting for them if they do not respect the unity of the human being. In this discourse the family cannot be properly established if “transmission of life” is performed in the laboratories and life originates in a petri dish “[...] one cannot use means and follow methods which could be licit in the transmission of the life of plants and animals” (Donum Vitae 1987).

All these worries listed above and the accusations issued against technological assistance in human conception seem to have one common basis. The major reasons for which the Vatican positions itself in such rigid opposition towards “artificial procreation” appear to arise from (1) fear of the objectification of the human/body and (2) the possible beginning of absolute technological supremacy. Here, I cannot help but quote Lauritzen again, who states that, “[...] the Vatican believes are quite clear: Persons will be treated as less than fully human; children will be thought of

largely as commodities; and interventions into the reproductive process will be judged solely by criteria of 'technical efficiency' in producing the desired product. The upshot will be the domination of technology over human reproduction, a situation in which persons will be reduced to objects of scientific technology" (1993:8).

For the Vatican the human being and "the special nature of the transmission of life" is not respected when assisted reproduction is evaluated from the moral perspective. Yet, another value, for which "the life of the human being called into existence" stands, becomes an issue in reference to which "the moral judgment" on assisted reproduction is conducted. It is interesting to notice that whereas the first concern over "transmission of life" may be seen as applying to the whole, particular nature of assisted reproduction, the second can be read as directly referring to embryos (and so future children) created in the process.

As the way in which life becomes "transmitted" is evaluated as improper, it is quite obvious that the life that originates from this particular "transmission" may not be seen as unaffected by it. In accordance with the Vatican "*The fidelity of the spouses in the unity of marriage involves reciprocal respect of their right to become father and mother only through each other*" and "*It is in their bodies and through their bodies that the spouses consummate their marriage and are able to become father and mother*" (Donum Vitae 1987). Only when those conditions are met "*The parents find in their child a confirmation and completion of their reciprocal self-giving: the child is the living image of their love, the permanent sign of their conjugal union, the living and indissoluble concrete expression of their paternity and maternity*" (Donum Vitae 1987). Thus, it becomes emphasized that, "*The child has the right to be conceived, carried in the womb, brought into the world and brought up within marriage: it is through the secure and recognized relationship to his own parents that the child can discover his own identity and achieve his own proper human development*" (Donum Vitae 1987). Therefore, if assisted reproduction does not seem to care about marriage and certainly does not demand the bodily contact (an intercourse) leading to the conception, not to mention the possible donation of gametes, a child can obviously not be seen as "*the living image of love*", "*linked to*

the union, not only biological but also spiritual, of the parents” and “the living expression” of its parents’ “paternity and maternity” thus it is inevitably “deprived of its proper perfection” (Donum Vitae 1987). From this it can also be concluded that a child conceived due to the methods enabled by technological development may easily be deprived of its basic rights. In addition, since love, intercourse and procreation are not succeeding one another, the human/body is thought to become an object; procreation gets the status of a commodity and so the child itself can easily qualify as a technological product and commodity as well. “In reality, the origin of a human person is the result of an act of giving. The one conceived must be the fruit of his parent’s love. He cannot be desired or conceived as the product of an intervention of medical or biological techniques; that would be equivalent to reducing him to an object of scientific technology” (Donum Vitae 1987).

What is more, “responsible parenthood” can only be maintained when marriage, love, sexuality and procreation are kept together. “By safeguarding both these essential aspects, the unitive and the procreative, the conjugal act preserves in its fullness the sense of true mutual love and its ordination towards man’s exalted vocation to parenthood” (Donum Vitae 1987). Therefore, I can conclude that participation in assisted reproduction, according to the Vatican, is not only disrespectful to parents and children conceived this way, but it also has nothing to do with proper parenthood. *Only respect for the link between the meanings of the conjugal act [intercourse linked to procreation]¹⁰ and respect for the unity of human being [physical and spiritual entity]¹¹ make possible procreation in conformity with the dignity of the person. In his unique and irrepeatable origin, the child must be respected and recognized as equal in personal dignity to those who give him life” (Donum Vitae 1987).*

The objection towards assisted reproduction is even stronger when the issue of donation gets assessed. “Recourse to the gametes of a third person, in order to have sperm or ovum available, constitutes a violation of the reciprocal commitment of the spouses and a grave lack in regard to that essential property of marriage which is its unity” (Donum Vitae 1987). Donation is also considered deeply harmful and

¹⁰ Emphasis added.

¹¹ Emphasis added.

dangerous as “[...] it offends the common vocation of the spouses who are called to fatherhood and motherhood: it objectively deprives conjugal fruitfulness of its unity and integrity; it brings about and manifests a rupture between genetic parenthood, gestational parenthood and responsibility for upbringing” (Donum Vitae 1987). Consequently the harm is done as much to the prospective parents as to the child who is seen as becoming deprived of “his filial relationship with his parental origins and can hinder the maturing of his personal identity” (Donum Vitae 1987). Moreover, such ‘formation’ is evaluated as constituting a real threat to the whole of society: “such damage to the personal relationships within the family has repercussions on civil society; what threatens the unity and stability of the family is a source of dissension, disorder and injustice in the whole social life” (Donum Vitae 1987).

Another objection towards assisted reproduction, slightly different in nature, has its roots in the Vatican’s position on human life in general. Approached from the Vatican perspective “life is sacred” and “from the moment of conception [...] is to be respected in an absolute way” as “it is [...] the life of a new human being with his own growth” thus “no one can, in any circumstances, claim for himself the right to destroy directly an innocent human being” (Donum Vitae 1987). Therefore, as “The implementation of procedures of artificial fertilization has made possible various interventions upon embryos and human foetuses” with “the aims pursued [...] of various kinds: diagnostic, therapeutic, scientific and commercial” it is no wonder that technologically assisted reproduction greatly perturbs the Vatican (Donum Vitae 1987). First of all, life is said to not be respected. Secondly, life is believed to be turned into an object exposed to mechanical decisions and excessive monitoring. In reference to the first objection, it is the embryo that is placed at the center of concern. In accordance with the Roman Catholic Church’s doctrine, an embryo is a human being. Thus the storing and freezing embryos is strictly disapproved “The freezing of embryos, even when carried in order to preserve the life of an embryo-cryopreservation-constitutes an offence against the respect due to human beings by exposing them to grave risks of death or harm to their physical integrity and depriving them, at least temporarily, of maternal shelter and gestation, thus placing them in a situation in which further offences and manipulation are possible” (Donum Vitae 1987). The possibility of destroying embryos constitutes the basis of

the Vatican's objection. Additionally, as the experiments done on embryos may also cause their destruction, it becomes emphasized that, "[...] since the embryo must be treated as a person, it must also be defended in its integrity, tended and cared for, to the extent possible, in the same way as any other human being as far as medical assistance is concerned" therefore "the practice of keeping alive human embryos in vivo or in vitro for experimental or commercial purposes is totally opposed to human dignity" (Donum Vitae 1987). According to the Vatican "[...] every human being is to be respected for himself, and cannot be reduced in worth to a pure and simple instrument for the advantage of others. It is therefore not in conformity with the moral law deliberately to expose to death human embryos obtained 'in vitro'" (Donum Vitae 1987). Logically, any biological and genetic manipulation of embryos ("fertilization between human and animal gametes", "gestation of human embryos in the uterus of animals," "attempts to influence chromosomic or genetic inheritance [...] not therapeutic but [...] aimed at producing human beings selected according to sex or other predetermined qualities") or cloning are forbidden and condemned as being in severe opposition "[...] to the moral law [...] the dignity both of human procreation and of the conjugal union" (Donum Vitae 1987). The Vatican's resistance to freezing, storing or using embryos for experiments results from the anticipation of their possible destruction (which is against the dignity of any human person) but there is also more to that.

Once more the scientist, seen as the one, who "[...] sets himself up as the master of the destiny of others [...]" fuels the Vatican's objections towards technological mediation in reproduction (Donum Vitae 1987). Regarding the assessment, the storing and the possible destruction of embryos, it becomes stressed that "through these procedures [...] life and death are subjected to the decision of man, who thus sets himself as the giver of life and death by decree" and that "such fertilization entrusts the life and identity of the embryo into the power of doctors and biologists and establishes the domination of technology over the origin and destiny of the human person" consequently "such a relationship of domination is in itself contrary to the dignity and equality that must be common to parents and children" (Donum Vitae 1987). Therefore, if the dignity of the human being wants to be preserved, "No one may subject the coming of a child into the world to conditions of technical

efficiency which are to be evaluated according to standards of control and dominion” (Donum Vitae 1987). At the same time the Vatican thinks that it is very possible that the prospective parents themselves may be completely unaware of the real nature of the methods proposed to them when emphasizing that/saying, “The dynamic of violence and domination may remain unnoticed by those very individuals who, in wishing to utilize this procedure, become subject to it themselves” (Donum Vitae 1987).

The Necessity to Ban IVF

For both the radical feminists and the Vatican new reproductive technologies such as IVF cannot be accepted and they should not be approved.

For the radical feminists the woman is positioned at the center of focus. According to them all women must join forces in order to oppose and reject the new conceptive techniques. The calling for resistance is expressed quite strongly when women are advised to react in any possible way. Jalna Hanmer makes it sound very dramatic when she emphasizes, *“We must begin all this immediately. For such is the pace of developments in the reproductive engineering field that by the time, a few months only from this writing, when the book is published [the book was published in 1984]¹², significant further advances in controlling women’s bodies are highly likely to have been made. We must act on our own behalf. Quickly. Better today than tomorrow – for it might be soon too late”* (Hanmer 1984:446). In a very similar vein, Renate Duelli Klein asks for the immediate organization of all women to stop the development of dangerous technologies pointing out that, *“We have little time as the international technology craze continues”* thus *“We must fight back”* (Duelli Klein 1985:71).

As I have mentioned the rejection in addition to, the necessity to not approve the technological assistance in reproduction are expressed and advocated by the Vatican. Contrary to the feminists, for the Vatican it is the couples and the future children who must be protected. With the family recognized as an institution, and therefore subject to the law of the state, the Vatican directs its call to policy makers, and state

¹² Emphasis added.

authorities, but also to medical staff. Evaluating new reproductive technologies as not respecting “the rights of the family” and “the rights of the marriage” the Vatican makes the state responsible for the protection of those rights. *“The intervention of the public authority must be inspired by the rational principles which regulate the relationship between civil law and moral law. The task of the civil law is to ensure the common good of people through the recognition of and the defense of fundamental rights and through the promotion of peace and of public morality”* (Donum Vitae 1987). As the Vatican sees technologically assisted conception to be a violation of the dignity of the family, they address those possessing powers of the State to not allow/prohibit the techniques they consider “illicit”. *“From the very fact that it is at the service of people, the political authority must also be at the service of the family. Civil law cannot grant approval to techniques of artificial procreation [...] and therefore civil law cannot legalize the donation of gametes between persons who are not legitimately united in marriage. Legislation must also prohibit, by virtue of the support which is due to the family, embryo banks, post mortem insemination and “surrogate motherhood””* (Donum Vitae 1987). The prohibition must be strengthened by the introduction of new legislation that will protect the family, keeping it as it had been before new reproductive technologies were introduced. *“It is to be hoped that States will not become responsible for aggravating these socially damaging situations of injustice. It is rather to be hoped that nations and States will realize all the cultural, ideological and political implications connected with the techniques of artificial procreation and will find the wisdom and courage necessary for issuing laws which are more just and more respectful of human life and the institution of family”* (Donum Vitae 1987). With the new methods of conception, the dignity of the couple, but at the same time, the dignity of the child is said to be in danger. According to the Vatican “the rights to live” thus “the rights of a child” must be absolutely respected. Therefore, *“The political authority consequently cannot give approval to the calling of human beings into existence through procedures which would expose them to [...] grave risks [...]. The possible recognition by positive law and the political authorities of techniques of artificial transmission of life and the experimentation connected with it would widen the breach already opened by the legalization of abortion. As a consequence of the respect and protection which must be ensured for the unborn child from the moment of his conception, the law must*

provide appropriate penal sanctions for every deliberate violation of the child's rights” (Donum Vitae 1987).

To conclude I want to emphasize that even if to a certain point the radical feminists and the Vatican differ in their positions, they still share a very radical opposition towards new reproductive technologies such as IVF. Therefore, from those two sides the absolute necessity to terminate technologically assisted conception has been articulated. I would argue that the negative assessment of, the conceptualization of and approach to new reproductive techniques such as IVF (the radical feminists and the Vatican) and their practice (the radical feminists) result from their theoretical foundations and their ways of confronting human in vitro fertilization. Furthermore, I also want to point out that because of this the debate itself becomes limited and thus rather inaccurate. I do not want to say that those theories and manners are intrinsically wrong, yet I do believe that when these two things are changed, more adequate and less negative evaluation, concepts and approaches can eventually be proposed. It is as Juliette Zipper and Selma Sevenhuijsen point out, *“It is not technology itself that complicates theory and strategy. What make it complicated are the terms in which technology and its social consequences are spoken about (...)”* (1987:120). Moreover, I want to contend that the radical feminists’ and the Church’s discussion regarding IVF allow particular ideas and notions (i.e. compulsory motherhood, victimized women, oppressive men or body-mind dualism) to strengthen and proliferate.

PART II

Zooming in on the Theories Used and the Manners of Discussing IVF

The Radical Feminists

Jana Sawicki (1991) points out that the radical feminists have always had the attitude that men want to control nature, women, and women’s bodies; especially their reproductive capabilities. In order to support their position, Sawicki argues, the radical feminists *“(...) give both psychological and historical accounts”* (1991:74). As men are said to aim at oppressing, abusing and controlling women/female bodies, new reproductive technologies such as IVF technique, which are thought to be a male invention, are immediately seen as equally oppressive and abusive. Because

technology is seen as the invention of the men, who are always oppressive, IVF technique can only be assessed as negative. “*Corea and other radical feminists demonize the technologies and the men who design and implement them*” (Sawicki 1991:70). Due to the same reasons, IVF technique and its practice are said to be child oriented, employed to increase control over women/female bodies, to take control away from women/female bodies and to maintain heterosexual families thus to strengthen the notions of motherhood and to increase patriarchy (what, again, confirms the oppressive and abusive ‘nature’ of IVF technique and practice). When IVF technique is seen as the invention of abusive man then the doors to any possible negotiations are closed before even being opened. Technology is oppressive and abusive since it originates from ‘men’s brains’. Period.

When IVF technique is seen as invented by men, who are oppressive towards women, it will always be assessed as not affecting its male users. Technologies are abusive because they are created and controlled by men, who are thought to be abusive themselves. It appears that the ‘scientist-men suppliers’ will not do harm to the ‘ordinary-men receivers’ as they basically have the same interest to get every woman pregnant. Therefore, even if men themselves opt for new conceptive techniques they will never be (negatively) affected by them and they will never experience what women will. However, to talk about reproduction as solely the women’s domain is, in a way, to allow men to shirk their responsibility in the process. Zipper and Sevenhuijsen emphasize that, “(...) *it was often voiced in the language of biology [that]*¹³ *women are seen as better carers by definition (...)*” (1987:123) and the arguments that radical feminists make seem to confirm such notions. Therefore, once more, only a woman appears to be the one to blame when conception is unsuccessful and the one to congratulate if her ‘duties’ are successfully accomplished.

For the radical feminists technology remains in opposition to the ‘natural’ body (in this case the female body) thus the crossing and dissolution of the boundaries between those two is thought to be extremely dangerous. Because IVF stands for a technological method it is automatically assessed as invading the ‘naturalness’ of the

¹³ Emphasis added.

body. Technology, thus IVF technique, is seen to be in opposition to the 'natural' body. As a result, IVF technique ends up evaluated as invading the body, reducing and turning it into object and a commodity (which supports the statement that IVF technique qualifies as abusive/oppressive). As to that the conviction that man stands behind technology is added then IVF technique is said to be always presented and described as of miracle-like, infallible characteristics and thought about as superior to the 'natural' body. Furthermore, the radical feminists also conclude that new conceptive methods such as IVF technique get applied because the female body is perceived as dysfunctional. However, such conclusions result from confronting IVF technique not only as remaining in the opposition to the 'natural' body but also as the invention of the abusive man. Yet, if human in vitro fertilization is going to be discussed as oppressive because it is 'man-originating', invasive, threatening and remaining in opposition to the 'natural', finding room for its possibly positive assessment becomes unattainable. Equally, playing notions of 'natural' against reproductive technologies becomes tricky, especially in reference to reproduction. For too long women have been made to occupy the 'natural', thus irrational and unpredictable, realm of reality to gain their independence under such label. Dion Farquhar emphasizes that to *"(...) assume essential universal connection between 'nature' and reproduction"* is to *"(...) deny the diversity, fluidity, and essential contested ness of representations of people's reproductive and maternal experiences or, alternatively, the host of reasons for the absence or displacement of these practices in their lives"* (1996:215).

Furthermore, in the feminists' discussion women are said to become powerless, neglected and are treated in the same way as animals. Moreover, women are described as mute and silent in their role in IVF technique and practice. Their ability to recognize their own needs are believed to get discredited. In addition, women and their bodies are believed to become controlled and subordinated thus oppressed. Next to that, it is stressed that the woman/female body becomes separated from the naturalness of conception, pregnancy, and birth, loses control over reproduction, gets fragmented, dismembered, reduced, turned into an object, commodity, dehumanized and is treated as a supplier of needed (genetic/gestational) material. Not surprisingly then reproductive technologies become evaluated respectively as subordinating,

separating, fragmenting, dismembering, reducing the woman/female body to merely a commodity and dehumanizing it. However, the conclusion that the woman/female body is respectively controlled, fragmented, objectified and powerless thus oppressed and so technologies are invasive, controlling, fragmenting, objectifying so all together oppressing, is possible because of the three factors. Firstly, IVF technique is seen as remaining in the opposition to the 'natural' body. Secondly, technology is confronted as the abusive man's invention. Thirdly, the woman/female body is in fact approached as, let me use this saying, being about nothing more than its reproductive organs and capabilities. Due to these theories and manners of confronting in vitro, the radical feminists' assessment of IVF will always be negative and the belief in its oppressive nature will consequently become strengthened. At the same time, due to such discussion concerning human in vitro fertilization the radical feminists diminish the importance of the woman/female body making it occupy a rather marginal position. Secondly, by presenting the body as merely a reproductive flesh onto which the technology operates and experiments, is to borrow, even if unwillingly, from the Cartesian philosophy. Jose van Dijck interestingly notices, "*Paradoxically, this feminist attempt to redefine reproductive technology dangerously approaches the dominant definition itself (...) it simply endorses the dualism (...)*" (1995:94). Thirdly, by suggesting possible fragmentation and dismembering, is to introduce a rather dangerous concept of the body. Fourthly, when the woman/female body is seen from the perspective of its physiology and reproductive organs, it is stripped of its multiplicity. Eventually, as the earlier mentioned Farquhar emphasizes, "*The insistence on maternal unity simplifies the variety of women's experiences of pregnancy. Such narratives about the pregnant body are invested in reaffirming traditional ideas of what women essentially are rather than contesting them or encouraging the construction of new ones*" (1996:212). In consequence, sharing the fate of their bodies, women appear to be controlled, powerless, reduced, reproduction oriented, thus oppressed and, worst, brainwashed as the rights and possible choices are said to be imposed upon them by a society dominated by patriarchal ideology. As a result, women and their bodies seem to become passive victims lacking the ability to think critically. They are set against 'the other side' of rational scientists and doctors who are deemed god-like, powerful operators of the new technological devices and techniques. Therefore, when seen

from the radical feminists' perspective, women opting for this technique and participating in its practice appear to have no other position to take but that of mechanical, manipulated marionette and the new technique and its practice are to blame.

Added to their negative perspective regarding in vitro is their way of seeing it mostly in terms of a particular technological method of conception and a medical technique. Little attention is paid to the fact that when applied and offered, IVF becomes a practice (organization/performance). Even when IVF is seen as a practice it is discussed more in terms of its similarity to something else (negative) or of its possible implementations and/or failures. Some examples include its similarity to animal farms, its possible implementation of the "brothel model", the possible existence of an "assembly line" or the possible invention of a "glass womb". Such conclusions, however, are mainly the outcome of seeing IVF technique and its practice as an abusive invention of men. It is going to be a reproductive brothel and a 'farm-like production' as men want woman to produce more and the best products possible. Because human in vitro fertilization is confronted in such manner, it is believed that in order to cause arguments among women (so they will no longer be willing to join forces to resist the introduced technologies) the access to IVF technique will be severely limited. Furthermore, IVF technique together with its practice are said to be strengthening the notions of motherhood and increasing patriarchy because IVF technique is always 'naturalized', always presented as the last chance with side effects, possible risks, physical and emotional involvement but also low success rates of infertility treatments hidden (what emphasize the abusive 'nature' of IVF practice) from the prospective patients. Yet, I want to argue such evaluation results from the fact of discussing in vitro as invented by oppressive man.

In addition in the feminists' debate IVF technique and practice are seen as if existing and functioning in an empty space far from historical, cultural, social, economical and political settings. It is discussed as being the same way everywhere. What is more, the whole focus is put on the IVF procedure itself. Yet, I do believe that by doing so the proper and adequate assessment of it cannot actually be made. This may sound quite paradoxical as one may ask on what else to concentrate if not on IVF

procedure itself when aiming at its evaluation? However, to have only this very process at the center of concern, from my point of view, is simply not enough.

What I also want to emphasize is the fact that the radical feminists seem to be speaking on the behalf of all women. To approach women as sharing the same characteristics and experiences is one of the weakest points in the feminists' debate. It is mostly because of this that the radical feminists have gathered so many negative remarks and criticism. Dion Farquhar writes that radical feminism "*believes that female 'experience' is universal. There are no exceptions, no individuals for whom they do not and cannot speak*" and that "*It is an irony of the development of feminist thought that some of radical feminist theory, fighting to distinguish itself from the near-hegemonic male voice of liberal discourse, should recapitulate the intolerance, authoritarianism, and universalizing representation it set out to combat. In massing women for political agency, radical feminism has legislated the essential similarity of women's "different" experience and attributes in contrast to an equally homogenized and underthematized similarity of "men's" experience*" (1996:217, 210). Even if there is an awareness of differences existing among women, those are only used to show how assisted reproduction will add to those differences. Therefore difference is understood negatively by following a logic that sees the group (women) as easier to control, the more it is divided.

In conclusion I would like to point out that by conducting such a debate regarding IVF, the radical feminists do not go beyond the reality constructed by patriarchy. Even if it is unwittingly, by using the same notions and rhetoric, patriarchy has been using for centuries; the radical feminists actually make the well-established ideology much stronger. The women and their bodies appear to always be abused, controlled, mute, passive and solely responsible for reproduction. The female body seems to be 'natural' and as such dysfunctional, prone to fragmentation, reduction and objectification. Michelle Stanworth emphasizes the shortcomings of such analysis not because it is very radical but because "*(...) in seeking to protect women from the dangers of new technologies, it gives too much away. There is a tendency to echo the very views of scientific and medical practice, of women and of motherhood, which feminists' have been seeking to transform*" (1987:16). Therefore by discussing

human in vitro fertilization in the way the radical feminists did everything that is criticized becomes, as I have said, strengthened. Furthermore, by debating IVF in the presented manners and with a help of highlighted theories, IVF has no chance to be evaluated accurately and in any other way but negatively as, let me repeat it once more, abusive and oppressive technique and practice.

The Vatican

To commence I would like to strongly emphasize that when focusing on the theories used in the Vatican's debate on IVF and on its manners of confronting in vitro, I am not aiming in any sense to conduct a polemic with the 'divine laws' the Vatican refers to. Yet, there is another, different in 'nature', kind of argumentation against these new methods of conception which I evaluate as inaccurate.

In the Vatican's debate, IVF technique is perceived through those who perform it. Even if it is explicitly stated that the technological realm is not condemned (technological methods thus all the machinery, tools and new devices) and is not rejected *per se*, it still cannot be accepted. This rejection, among others, comes from the fact that IVF technique is believed to be in the hands of the scientists and doctors and is seen as aiming to control reproduction, thus usurping the rights of God. As the scientific and medical field, thus the scientists and doctors, are believed to be solely progress and betterment oriented so is IVF technique. Even if those factors are crucial in other medical branches they are not sufficient in the reproductive sphere. First of all, conception should be about love, warmth and, in a way, secrecy, and the laboratory spaces simply cannot secure such things. Secondly, the "transmission of life" should not be turned into a field of interference. As the scientists and doctors are said to be willing to gain control over the beginning of the human life and as such qualify as an oppressive group, the technique is assessed to have the same characteristics. There is a fear that human reproduction will become dominated by technology which eventually will lead to an absolute technological supremacy. As IVF technique is seen as a human invention, it becomes evaluated as used not only to gain control over the origins of all human beings but also to offer miraculous solutions. IVF technique is assessed as controlling, thus abusive, because the aims of those who operate it are defined in the same terms. Furthermore, as the fact of

conception constitutes the major point of concern, the very method, technique *per se* becomes the only one addressed. In consequence, when in vitro is discussed it is not seen as a practice (organization/performance). Similarly to the radical feminists, the Vatican discusses human in vitro fertilization as if it was functioning in an empty space and the whole focus is put on IVF procedure itself. However, as said before, focusing only on that aspect is not enough. What is more, in contrary to the feminists, the Vatican assesses IVF technique as not only oppressive towards women but also couples, future children and embryos, thus the whole of humankind. Therefore, in a way, the fact of male participation in the process becomes confirmed. Yet such acknowledgement is not seen as something positive but is used in order to emphasize the wide range of those who may be negatively affected and harmed by this new method of conception. At the same time all the addressed possible participants (women and men) are seen as one group with the same characteristics.

In the Vatican's debate on IVF technique, the very manners of conceiving appear to be crucial for defining social formations as families. Those are the modes of conception which allow one to speak of family and parenthood or not and which grant their particular status. Moreover, the modes of conception are recognized as crucial for securing the expression of love and care and protecting against reduction, objectification and commodification of the human being and its body. In this sense the methods of conception are also made responsible for the assurance of respect, thus the dignity of human beings. For the Vatican, only if the link between sexual intercourse and conception is preserved, can the partners and their children be described as a family, i.e. the proper formation of parenthood may take place and the respect, thus dignity of the human beings, can be maintained. This is mostly due to the fact that the maintenance of this link is said to allow the real articulation of love through the body and to prevent humans and their bodies from being reduced to mere objects. The articulation of love and the prevention of objectification love secures is essential if the proper forms of family and parenthood are to be established. In Donum Vitae (1987) the Vatican opposes its description of procreation and so the proper way of creating a family to assisted reproduction (IVF technique) and the 'formation' that can be obtained due to this technology. IVF technique becomes rejected as not allowing a proper formation of family and parenthood because the

link between sexual intercourse and conception is not preserved. Therefore, the expression of love cannot take place and the human being together with its body is said to become reduced and objectified. Because of these IVF technique is assessed as disrespectful because of depriving human beings of dignity (humans are no longer “unified totalities”). In the Roman Catholic Church’s doctrine every human is seen as a physical and spiritual unity. The encounters between partners, especially those aimed at reproduction, contain in themselves both the physical and spiritual elements. The sexual intercourse, which should lead to conception, is thus defined as physical (involves a body) but at the same time as spiritual (originating from and simultaneously expressing the love between partners). The sexual intercourse is said to allow the human being to manifest itself and its love through its very body. In this sense, the sexual intercourse makes an expression of love possible and allows the body to become an expression of love itself. As assisted conception has nothing to do with the corporeal conjunction, it is also said to have nothing to do with love and the possible expression of a mutual caring. Thus as not demanding corporeal connection, the IVF method is thought to not allow love to be expressed through the body, preventing love from being actualized, reducing the body to mere flesh and reducing the human being to its physical level. If love cannot be articulated *via* the body and the human body becomes nothing more but an object, then the real family cannot be formed, the proper parenthood cannot be developed and the dignity cannot be preserved. In this I see a very particular reduction, even if not aimed, of the relations between human only to the modes of reproduction themselves. At the same time it appears that the manners of conception alone are seen as a guarantee of the future well being of partners and their children. Certainly, the link between sexual intercourse and conception is broken when the new conceptive techniques are applied. However, I would like to argue that the Vatican’s conclusion that assisted reproduction does not allow love to be actualized and is responsible for reduction and objectification of the subject and its body, results from the theories employed in the Vatican’s debate on IVF. First of all, as I have said, the maintenance of the link between sexual intercourse and conception is absolutely crucial. Whenever the maintenance of the link may be in ‘danger’, everything that can cause that becomes immediately disqualified and rejected. Only if the link between the sexual intercourse and conception can be preserved are couples believed to remain the

“unified totality”. If not, they are said to lose it. As assisted reproduction does not allow the link to be maintained, it becomes responsible for the reduction of the couples’ bodies and as such for the loss of dignity. As a consequence, it is said that when the body is technologically assisted, the human being undergoes a severe split between the flesh and the will. Simultaneously, will and love are believed to be neglected and, in a way, completely eliminated from the picture. What remains is solely the physical realm of the body. When the division is said to happen, the person becomes thought about as losing its human dimension, its body turning into a meat-like surface for medical manipulations, becoming an object and reaching a status of commodity that can be modified and enhanced. Having said that, I want to contend that the conclusion that assisted reproduction does not allow love to be actualized and permits reduction of humans and their bodies results from the, so to say, glorification of the sexual intercourse as the expression of the unity of the human being. Secondly, to me, such a conclusion can be reached because the Vatican sees the human subject/body as being basically about its reproductive capabilities and reproductive organs as the sexual intercourse is seen as a *sine qua non* for love to be protected and for love to be properly expressed. Consequently, even if, for the Vatican, the human being stands for unity, what actually becomes established is the concept of the human being that may undergo a division followed by a reduction (body reduced to its physical level). If, however, the human is seen as unity, nothing should, in fact, be able to cause its division. Yet the moment the split and reduction are believed to occur, it seems that from the first place the unity was rather an uncertain assumption. Furthermore, with the focus solely on the “ways of transmitting life” as conditioning everything, it appears that the human subject/body has only one level to function and operate on. It is as if the human subject/body when it is seen as ‘child-reproduction-oriented’, exists only in the very moment of conception. Therefore, it is possible to assume that while being against approaching any human subject/body from the perspective of its reproductive dimension, the Vatican does what it opposes. As a result, the human subject/body seems to not be able to act, be, or become on other levels though the Vatican itself seems to be very concerned with recognizing the human being/body in just such a multi-leveled way. In addition, it also becomes said that in assisted reproduction the body is seen

through the prism of its organs and tissues, again thus reduced and in result objectified.

The modes of conception are also recognized as the factors determining the status of the child. The norm (sexual intercourse followed by conception) that IVF technique does not obey allows their immediate negative evaluation. Additionally, it also allows presenting a child as deprived of its 'natural' perfection. The involvement of technology in reproduction is seen as not allowing love to be actualized, responsible for the subject's/body's reduction and the eventual loss of the dignity. As the parental bodies are said to experience particular reduction and both women and men do not remain the "unified totality" the prospective children are talked about as not "linked to the parental union of body and spirit" thus not resulting from its parents' love and so deprived of the most important human value but also deprived of the perfection and dignity. The love for a child and desire to have one appears to have a meaning only when expressed in the intercourse leading to reproduction. The moment technological mediation is at stake the love and desire for a child become compared to any other desire for any other good offered in contemporary world. Therefore, a child itself becomes equal to various objects or any other offered goods that can be obtained and possessed.

Furthermore, as embryos can be exposed to assessments, quality selection, freezing and storing practices, and what is worse, possible improvement or eventual destruction, reproductive technologies are evaluated as controlling, dignity depriving, and of turning embryos into objects of scientific interest, thus reducing children and humans to objects, automatically objectifying them. What is absolutely interesting to notice here is that the embryos are talked about as 'not belonging'. They are discussed only through the prism of those who operate technologies such as human in vitro fertilization technique.

Conclusion

As argued above, the very negative assessment of, conceptualization of and approach to IVF technique (the radical feminists and the Vatican) and IVF practice (organization/performance) (the radical feminists) seem to result from the particular

theories used in IVF debates and certain manners of confronting human in vitro fertilization. For the radical feminist the human subjects live in a patriarchal society and a man has a dominant, oppressive and controlling 'nature'. In addition, all his devices have power and control inscribed in them. Thus, whatever a man invents, whatever a man operates, signals the oppression in motion. This abuse is especially visible when nature, women and their bodies are at stake. When technology and its practice are confronted as originating from an abusive man, IVF technique/practice has no other way to go but to the realm of control and oppression. The Vatican sees the scientists and doctors, who deal with human reproduction as those wanting to be in charge of human life and as such, usurp the power of God. With IVF technique confronted in such manner it cannot count on any other evaluation but negative. Furthermore, when technology is theorized as remaining in the opposition to the 'natural' body, IVF technique must be assessed as invasive dangerous and dehumanizing. In addition, when the human body and the human subject are theorized as being mainly about reproductive capabilities (though neither the feminists nor the Vatican seem to be aware of such approach) where sexual intercourse appears to be able to assure the unity of the human being (the Vatican) then it is no surprise that IVF technique becomes 'accused' of reduction, objectification and commodification of the human body and the human being. With such theories and manners of confronting human in vitro fertilization the assessment/conceptualization/approach will always be negative. What is more, the assessment/conceptualization/approach is also, to a certain degree, inaccurate. The manners of confronting in vitro employed by the radical feminists and the Vatican pose important limits on the whole discussion and make it very narrow. It is because they do not allow many other important factors to be taken into consideration when debating human in vitro fertilization. To give some suggestions I want to point out that the Vatican does not see in vitro as a practice (organization/performance), not to mention that it does not see it (as the radical feminists does not) as the practice located in time and space. Neither the Vatican nor the radical feminists confronts in vitro as a phase of a longer and broader procedure. They also seem not to realize that those who opt for new methods of conception and their practices do not share the same characteristics, do not form one mass, do not have one 'shape'. Furthermore, on a slightly different note, I want to stress that the radical feminists' and the Church's

discussion concerning IVF allow particular ideas (that the feminists and the Vatican are in fact against) to grow stronger and proliferate. My point is that in the feminists' debate a woman and her body seem to still occupy the marginal position whereas in both the feminists' and the Vatican's discussion Cartesian dualism appears to be constantly present and the human body/subject seem to be lacking all its multiplicity and variety.

CHAPTER TWO

The Visual Dimension of Human In Vitro Fertilization

PART I

The Concept of IVF in the 'Visual Matrix'

There are three types of images, which are used in order to visually represent human in vitro fertilization. After browsing and getting acquainted with many websites such a conclusion becomes simply inevitable. Those visual images form a basis, on which the concept of human in vitro fertilization gets established and formalized.

The most common images are those of the interior design of infertility clinics. An enormous variety of tools, machines and apparatuses are what usually get visually represented. The images range from those representing cabinets, in which the observation of stimulated ovaries and retrieval of egg cells take place, the laboratory spaces, where the microscopes, micromanipulator controllers used for the IVF-ICSI (Intracytoplasmic Sperm Injection), incubators, plastic dishes with collected genetic material, controlled rate freezers, straws to freeze embryos in, and storage tanks where sperm and embryos are kept, to the rooms where fertilization is performed with the help of the highly sophisticated machines. People who are at work, operating various apparatuses, controlling their application, checking the progress, and in general, supervising and monitoring the whole process, are also visually present. Next to those, the image of a spermatozoid being inserted straight to an egg can always be found when IVF is visually described. What is shown is a dark, oval shape on the one side of a picture and on the other, a long, thick line. This image is usually followed by another one which shows the line making contact with the dark, perturbant-like (this sensation of perturbancy is created due to differently spread shadows on the surface) oval form. The final image shows the line being inside the oval, whose one side appears to be significantly deformed and waved.

Therefore, it is not surprising that when faced with visual representation of IVF, a viewer can relatively easily realize that in vitro fertilization is definitely about technological performance and its application in the realm of human reproduction.

Furthermore, the laboratory spaces, tools and machines applied during the process may inevitably evoke associations of the productivity of a well organized factory. Therefore, the possible supremacy, potentiality and power of the used technologies can facily be sensed. In addition, the images of doctors and technicians show that human reproduction has been turned into a controlled phenomenon. What is more, the image of a spermatozoid inserted to an egg cell enables sensations that it is mostly the moment of fertilization, the very fact of reproduction that is at stake here and which gets absolute priority. Moreover, the displayed connection of gametes creates the assumption that the process is closely controlled and rather simple. Based on that, it can be assumed that the process must also be predictable, thus probably very successful. In addition, as *“the moment of conception used to be symbolised by a love story, that is today depicted as a story about the egg and sperm”* what is achieved is *“the undisturbed image of a monogamous, heterosexual union of he and she”* (Lie 2006:7). In this sense, IVF seems to be a medical procedure that not only is paralleling ‘natural’ processes but also promoting heterosexuality.

Described images are usually accompanied by those of the human body’s interior. Those images differ significantly. When the stimulation of ovaries or egg retrieval are visually presented, what can be seen are the ultrasound images of dark, grey, white, shapeless, formless and balloon-like stains and dots with blurred and effaced boundaries – the image resembles more an abstract painting than body interior materiality. If the image is of an egg aspiration the needle can easily be distinguished as a long thick white line. The egg cells and spermatozoids, which are visible due to the utilization of microscopes usually during their evaluation and preparation for fertilization, constitute a high percentage of all the displayed images. The shapes of eggs vary. The usually grey, big, round, oval, or ellipse-like forms can be more or less fragmented. Sometimes the egg looks like an empty balloon; sometimes this balloon contains smaller rounded circles, and sometimes those rounded forms are situated on its curved edge. The egg may once appear as a flat surface more like an effaced negative of a picture of a big omelet with beans scattered around, and at other times seem to be protuberant, resembling a three-dimensional sphere. The ball-like forms that can be seen have mostly nothing in the background, which remains pure and transparent. Yet there are images, in which the ellipse of the egg is located

among other shapeless forms surrounding it. The spermatozoids appear as grey, black or white dots in different shapes and sizes with long, winding and split grey lines behind them. Depending on the image, there could be only one spermatozoid or a whole group of waved lines scattered around. The background of the image usually remains transparent and only sperm can be seen, yet it can be that the horizontal and vertical lines crossing each other (counting chamber-hemocytometer) constitute the background and in the foreground, black dots and dark lines (spermatozoids) are displayed.

With the body's inner elements and pieces on display, it becomes easy to assume that with the application of new conceptive techniques such as IVF, the human body definitely gets fragmented and disassembled. Furthermore, when those interior body parts are presented, assisted reproduction may easily be evaluated as reducing the human body to a purely physical/physiological surface and turning it into an object. Steven Mentor writes that as far as visual representations of IVF are concerned *"There are no pictures of women undergoing IVF or the related procedures, but we do see diagrams of laparoscopy and ultrasound aspiration"* (1998:75). In a similar vein Laura Shanner and Anne Balsamo emphasize respectively that, *"(...) Women literally fall of view in prenatal imaging techniques (Stabile 1992)"* (Stabile (1992) in Shanner 1998:430) and that *"(...) the female body is "deconstructed" into (...) parts and pieces"* (Balsamo 1996:81). Merete Lie's (2006) also confirms such state of affairs. She emphasizes that, *"Currently, the egg and sperm are generally used to illustrate stories about new reproductive technologies"* (Lie 2006:7). To that I would only add that the male body, similarly to the female body, does not appear either. Therefore, with only the inner elements on display, the human body seems to become nothing more but a supplier of the needed materials crucial for reproduction. Thus, IVF seems to be solely about the autonomous, 'not-belonging-to-anyone' inner body parts and is thus negligent, implying that whole human bodies are of no interest when IVF is applied. The authors of Global Nature. Global Culture (2000) mention that, *"The fantasy of autonomy from the mother is extended in popular representations that have fetishised technologies as modes of reproduction in themselves"* (Petchesky in Franklin, Lury, and Stacey 2000:35). In addition, those dark spots, waved lines and deformed shapes hardly allow recognition that what is dealt with is,

in fact, a part of the body, a living organism. Therefore, it is possible to perceive it as an object and a surface of/for experimentation. Next to that, with the images of stimulated ovaries, of aspiration of egg cells, of insertion of a spermatozoid into an egg cell and embryo transfer it appears that the reproduction of human bodies and the human bodies themselves (females and males) are taken under a strict control. This is due to the fact that those images, apart from the body fragments, also display medical instruments which can implicitly indicate control that is present during the whole process. Eventually, with the particular body elements on display, it can easily be assumed that the whole process is very short in time, thus probably relatively easy to perform and not very demanding. Thus, it can also be concluded that to participate in IVF does not require much physical, psychological and emotional efforts, or any kind of preparations from the patient's side.

The images of embryos constitute the third type of images used to visually present IVF. Franklin and Roberts emphasize that, *"(...) the embryo is literally becoming more visible, somewhat like the foetus, now rising above the horizon of its former invisibility to become, if not yet iconic, a powerful 21st century visual image. For example, the embryo is beginning to make appearances within the mass media in brand images, in advertisements, in news programmes, and in various other contexts. As well as images of fertilised eggs and human embryos, images of embryo manipulation in the form of microinjection imagery have become more visible (...)"* (Franklin and Roberts 2001). Similarly to those of ovaries, egg cells and spermatozoids, the embryo images vary significantly. There can be many circles joined together forming nice, clover-like forms or there can be one big oval containing different pieces varying in sharpness, resembling mountain peaks. Some can look almost like the face of Mickey-mouse, and some like the antic clepsydras. With such images on display it is almost impossible to really associate them with anything, especially not with the body of a prospective child/human being. Therefore, an association with, let me use this expression, some kind of an object can easily be made. Furthermore, I would also like to point out that when the images of embryos as autonomous, 'not-belonging-to-anyone' (Franklin, Lury, Stacey 2000; Franklin and Roberts 2001) appear, it becomes possible to see those very embryos as

being turned into nothing more than objects of scientific interest when assisted reproduction is at stake.

When IVF is visually presented and described, it becomes possible to see it as a procedure in which the human body is treated as a supplier of needed materials, gets fragmented and reduced to a physical/physiological surface, and is turned into an object. In addition, because what is shown can hardly be recognized as belonging to or being a living organism (human), the images can easily be interpreted as being merely some sort of object. Furthermore, it also seems possible to state that IVF is a technology where the embryo sharing the 'fate' of the female and male bodies, also becomes turned into an object of scientific enquiries. What is more, the reproduction itself appears to be the only thing that counts. In addition, the whole process seems to be short in time, easy, not physically, psychologically or emotionally demanding, predictable and successful. It seems to parallel 'natural' processes and promote heterosexuality. IVF appears to be all about technological supremacy in which human reproduction and human bodies are taken under close and strict control. Furthermore, when visually described IVF seems to turn human reproduction into a strictly technological phenomenon, reproduction without bodies, without pain; reproduction totally based on technological inventions and tools that seem to be sufficient in themselves, and in fact, all that is needed to pass life on. In result, it can be repeated that when IVF is presented with the help of the visual images what becomes established is a concept of IVF as of fragmenting and disassembling bodies, reducing them to objects and turning them into suppliers of the needed materials (for the sake of conception) medical procedure. IVF appears to be a powerful and controlling technology, which also turns embryos into nothing but objects.

PART II

The Peculiarity of the Medical Field

The central question in this section concerns the medical field and its possible 'contribution' to the circulation of the particular visual representations and so concepts, of IVF.

Human in vitro fertilization belongs to the domain of medicine. The desire to know and to understand has always been present in this particular field of science (van Dijk 2005). There has been a curiosity which has fueled general medical progress and development. In the medical field the human body has always been approached as an object to study, as a *terra incognita* that must be discovered, explored, and more importantly, comprehended. The general attitude to what was to be examined and investigated has been far from sentimental or sympathetic. The medical field has always been about studying, getting into the very core of human corporeality without a pardon or unnecessary politeness. Jose van Dijk, mentioned previously, makes this fact very explicit when she stresses that, “*The patient’s body is reduced to an operating area, a silenced object, veiled except for the sterile opening in the skin. Anesthetized and unconscious, the patient becomes a virtual participant, talked about but not talked to; (...) (2005:67).* Therefore, it can be easily concluded that the body of a person when examined and investigated has not been treated differently from any other scientifically approached and studied object. This objectification of the body that signalizes that the body has been approached from outside, thus as an object, has been widely practiced.¹⁴ The ‘body-becoming-an-object’ has also been conditioned by the fact that the medical sciences, as Nina Lykke stresses, “*(...) are expected to explore the non-human, which includes the biological dimensions of the human body (...)*” where the non-human is cast “*(...) in the role of a mere object (...)*” (1996:15, 24). As I have already emphasized, the body wanted to be known. Therefore human physiology, the working, operating and functioning of the body have constituted a major interest for generations of those associated with medicine. Consequently, the inner dimensions of the body have started to be treated as a *sine qua non* for the necessary knowledge to be gathered. It does not have to be mentioned that an interest in ‘what goes on inside’ has been the interest in organs, tissues, soft and hard components, their mutual connections, physical and anatomical details of the human corporeality. Lisa Cartwright points out this fact, when she refers to Foucault in her writing, saying, “*(...) the institution of pathological anatomy entailed a shift in focus from symptoms to organs, sites, and causes. With the rise of physiology later in the century [sixteenth century]¹⁵, the body was reconfigured as a system, a network of functions taking place across organs and*

¹⁴ Lecture with Prof Annemarie Mol on March, 22, 2007 at Utrecht University, The Netherlands

¹⁵ Emphasis added.

sites. *Viewing the body and its parts as static entities and reading its surface alone were no longer viable methods of determining pathology*” (1995:47). At the same time, as Ludmilla Jordanova notices that vision has been treated “(...) *as the privileged route to knowledge (...)*” (1989:158). It has been believed that by making the interior of the body visible, the needed information could have been collected and the desired knowledge could have been gathered. Rosi Braidotti writes, “*According to psychoanalytic interpretation, the scopic drive is linked both to knowledge and control or domination. In other words, the practice that consists in opening something up so as to see how it functions; the impulse to go and see, to “look in” is the most fundamental and childlike form of control over the other’s body. (...) the desire to see (...) leads to knowledge and to control (...)*” (1994:67). Thus, as van Dijk emphasizes, “*Ever since the Renaissance, looking into the body’s interior has constituted the empirical imperative of medical science,*” “(...) *by looking into bodies (mostly corpses), doctors could increasingly understand the secrets of human physiology*” (2005:4, 15) In the same vein, Karen Newman points out that, “(...) *medical knowledge came to be produced and understood through anatomical observation*” (1996:1). Enough to repeat after Berengario da Capri who practiced pathological anatomy in the sixteenth century in Italy and emphasized that, “*the experience of my eyes is my guiding star*” (Turner 1987:31). At the very beginning of a slow but consistent medical progress in order to see what was underneath, was to literally enter the body. To reveal what was hidden inside, as Michel Foucault (1994) stresses, corpses must have been opened. As van Dijk mentions, “*Anatomical dissection is considered an essential ingredient of medical training. By looking at and cutting into dead bodies, future doctors learn to distinguish between healthy and diseased tissue in living bodies, and also gain an understanding of the three-dimensional shapes of organs, veins, and bones. “Anatomical dissection” literally means, “Separating the body into pieces”; this systematic disassembling of the physical body is justified because it results in an entirely new body—a body of knowledge*” (2005:119). Yet, to open and to see was not enough. For knowledge to grow the, so to speak, opening was usually followed by the performance of dissections. Therefore, to obtain the needed information the body was not only widely opened, but also disassembled (Jordanova 1995; van Dijk 2005). The dissected inner body parts were crucial for the production of medical knowledge. By

getting to know how the parts functioned and what role they played in the whole body system, the operating of the body as such could be better understood. However, in order to communicate this knowledge to one another and to have their knowledge grow accordingly, the doctors'/scientists' visual contact with the interior of the body and all its inner elements had to be translated into readable signs. Consequently, the body's interior became visible in the form of drawings and anatomical illustrations. Jordanova emphasizes, *"By the eighteenth century, many sumptuous books were available that recorded the results of dissections (...)"* (Jordanova 1995:203). Van Dijk also points out to this, *"Cadaver dissection does not provide the only occasion for medical students to become acquainted with organic human architecture. Anatomical illustrations help them conceptualize the forms and structures of various organs before they actually touch them. Without these two-dimensional representations, a thorough understanding of the body's physiology would be inconceivable. Ever since the sixteenth century, knowledge derived from close observation of cut-up cadavers has been recorded in drawings and anatomical atlases. To convey their empirical findings, anatomists depended on the precision and craft of their illustrators.[...] From the early days of anatomy, then, anatomical training has been based on dissecting bodies and studying anatomical illustrations"* (2005:119). Ludmilla Jordanova also points out the fact that the field of medicine unarguably situates itself among *"(...) institutions explicitly focus on picturing the body"* (1989:43). Thus, it can be concluded that, *"(...) medicine can be seen as a powerful form of (...) representation of the body as flesh"* (Turner 1987:19).

From what I have presented, I can easily conclude that in the medical practice since the very beginning through the sixteenth century with its development of pathological anatomy and the hospital as an institution (as an apparatus of examination and the place of the medical gaze) (Turner, 1987:37,) the body has always been treated as an object to study and its physiology (how it works, functions and operates) has usually been focused upon. Moreover, the anatomical dissections, interest in the inner bodily fragments and human physiology can easily be evaluated as fragmenting and disassembling the body's totality. The fact that the human body stands for acting, experiencing, remembering, feeling, desiring, affective and emotional matter that is embedded in political, economical, social or cultural settings

seemed not to constitute the realm of an interest and concern (Martin 1987). Those issues were thought of as subjects to be wondered about mostly by philosophers. Therefore, I can suggest that the manners of approaching and treating the human body in the medical field resulted in fragmenting, objectifying and reducing the body to physical/physiological surface. Karen Newman (1996) but also Emily Martin (1987) both appear to confirm this statement. Newman strongly points out the fact that in the medicine *“Knowledge was produced by the observation, dissection, and isolation of individual structures and by their taxonomic organization, a reductionist program (...) The physician is a mechanic or engineer, the body an engine or robot of assembled, isolatable moving parts and systems”* (1996:94). Martin on the other hand, writes that, *“(...) many elements of modern medical science have been held to contribute to a fragmentation of the unity of the person. When science treats the person as a machine and assumes the body can be fixed by mechanical manipulations, it ignores, and it encourages us to ignore, other aspects of our selves, such as our emotions or our relations with other people”* (1987:20). She also emphasizes the fact that, *“The body as a machine without a mind or soul has become almost familiar, but the body without the integrity of events of its parts will necessarily lead to many readjustments in our conceptions of the self (...)”* (1987:20). In addition, as those were mostly the body parts and elements that got the highest priority, it is possible to say that the body was treated and reduced to nothing more but the supplier of the needed to study materials. Yet, the described medical manners of approaching the body, but also of communicating knowledge of it, also resulted in the production of the visual images of the body, but more importantly, of its inner parts and elements (anatomical illustrations). Thus, I can argue that both the manners of treating and of debating/discussing the human being made the production and circulation of the visualized inner body parts and fragments possible. At the same time keeping in mind Ludmilla Jordanowa’s suggestion that, *“Science and medicine have acted as major mediators of ideas of nature, culture (...) with verbal and visual images as the tools of that mediation”* and that *“(...) science and medicine tells stories and produce images that convince both ‘experts’ and others (...)”* it is not surprising that with their (images) increased proliferation, the human body could have been easily perceived as disassembled (1989:42, 158). Furthermore, when the bodily elements got the status of visibility, the body they belonged to became

invisible and absent. What is more, as those were the inner body fragments that got visualized and so physical parts *per se*, the body could have been seen not only as a supplier of the needed to study material but also as a system of the connected physical components thus a physical/physiological surface itself. In this sense I can conclude that the manners of approaching, and so to say, passing the knowledge of the body resulted in the production and circulation of anatomical illustrations (the visual images of the inner body fragments). By doing so they allow perception of the body as disassembled, reduced, turned into an object, supplier of needed materials. As already quoted Rosi Braidotti emphasizes, “(...) *clinical anatomy* (...) *By trying to reduce the body to an organism, a sum of detachable parts (...) implies that the body is but that: what you see is what you get*” (1994:67). Mentioned elsewhere Karen Newman, writing about the history of obstetrical visualization, also makes the medical field responsible for establishing particular concepts of the body. She says that, “(...) *positivistic view of anatomy produced the body as a series of parts to be manipulated*” (1996:51).

Yet, one may wonder what the practices of the medical field have to do with the visually established concepts of IVF and I would say plenty. In Part One, I said that human in vitro fertilization, when visually represented, seems to be responsible for fragmenting, reducing and turning the body into an object. In this section I have managed to demonstrate that because of the practices of the medical field, the images of the inner body parts could have been produced and circulated thereby evoking the sensations of fragmented, reduced and object-like bodies. Anatomical illustrations have certainly been a *sine qua non* in the domain of medicine and medical knowledge has been communicated with and gathered on the basis of the visualized body's interior. Thus, it is of no surprise that when any medical procedure, including IVF, is described, the inner body parts usually get displayed. When those bodily fragments appear, they evoke associations with fragmented, reduced and objectified bodies, which may evoke paranoid fears. The visual representation of IVF as a procedure, in which the body gets disassembled, reduced and becomes object-like fits into this long and strong tradition of medical representations of the human corporeality. To summarize, I want to once more emphasize that the images of the inner body parts and the sensations they may evoke result from the fact that medical

field has been based on the inner body fragments and how these fragments were visualized. Thus, when the concept of IVF is visually established as procedure that disassembles and reduces the body, this is due to the general/traditional approach to and discussion of human corporeality in the medical field.

Visual Technologies and the Medical Field

The medical field has its 'share' in the current circulation of the particular visual representations, thus also concepts of IVF. In this section I want to find out if the same can be said about the visual technologies intrinsic to the medical field.

The gradual and constant development in medical imaging technologies has been linked to, but also significantly influenced by the innovations in media technologies such as photography as well as video and computer technology (van Dijk 2005). Therefore, it is not too much to say that those fields has fueled each other's evolution and progress. The first very simple machines have been consequently replaced with more and more advanced technologies. It has not only been the medical field that has been interested in improving the methods of visualization of the human body. The, so to say, visually oriented business has also started to bloom. The highly differentiated professional groups of people, including doctors and scientists, but also those linked to production and marketing have fueled the constant development and proliferation of visual technologies. Nowadays, for example, under the umbrella of physics departments, there are many image science institutes that closely cooperate with the medical centers.

Medical practice and discourse have always treated the human body as an object to study and its functions/functioning of organs, tissues and various systems have invariably constituted the main target for doctors. Accordingly to the feminist's scholarship especially the female bodies have wanted to be "*explored*" and "*conquered*" (Shohat 1998). At the same time it has constantly been believed that by the very fact of making the body visible, knowledge about it can be collected. Therefore, it is not too much to say that in medical practice the possibilities of making the body visible has remained the most important objective. Rosi Braidotti points this out writing that, "*There is an inevitable slippage from the visible to the*

mirage of absolute transparency, as if the light of reason could extend into the deepest murkiest depths of the human organism. As if the truth consisted simply in making something visible” (1994:67). Without doubt, I can say that medical practice has always been preoccupied with delivering the unmediated truth. This aim, present in the art of medicine, is as van Dijk rightly notices, rooted in positivist theory which comes out of a time when scientists “(...) *promoted objectivity, methodological consistency, and standardized observations as guiding principles in both medical science and practice*” (2005:84, 86). In the medical field the belief in the visible is enormous. Visual technologies enable the visualization of the body’s inner organs, systems and the tiniest, invisible components. They increase the accessibility of the body (Braidotti 1994; Sawchuck 2000; van Dijk 2005). They can explore and deliver “*postmodern cartography of the female interior*” (Shohat 1998). They are believed to deliver images that stand for the “*perfectly mechanical reproduction of (...) bodily interior,*” objective visual representation, accurate, unmediated evidence and “*solid scientific and definitive proof*” (van Dijk 2005:86). As a result there is of no surprise that these technologies have been immediately implemented in the field of medicine. Lisa M Mitchell and Eugenia Georges write that, “*The sense that what is seen on the screen is “really real” (...) derives from the codes and conventions of visual realism (...)*” (1998:117). New visual techniques have not only been applied to increase knowledge of the human body, but also to bring answers to particularly posed questions, to clarify situations and to help explain ambiguities. In this sense, what is seen becomes the basis upon which decisions and choices concerning further medical courses of action are based. A particular technique is used, the body, or more precisely the targeted parts, become visible and even if what is seen cannot in many cases help to solve the problem, it still allows certain actions to be undertaken. Yet, the visual technologies are not only used for diagnostic reasons. Their presence is equally important carrying out the medical procedures as the treatment itself. Therefore, I can say that in contemporary medical practices, almost any procedure involves the application of visual technologies and behind any medical protocol stands a particular visual apparatus.

Medical imaging and media technologies certainly give “(...) *the public access to new images of the body and what it is made of (...)*” and “(...) *new images allowing*

us to perceive what happens inside the body” (Lie 2006:7). However, with the increased possibilities of seeing, it has again been the inner parts and elements that have become visible/visualized. With only fragments present, the body as whole has remained invisible and absent. Donna Haraway emphasizes that, *“The eyes have been used to signify a perverse capacity – honed to perfection in the history of science tied to militarism, capitalism, colonialism, and male supremacy – to distance the knowing subject from everybody and everything in the interest of unfettered power. The instruments of visualization in multinationalist, postmodernist culture have compounded these meanings of dis-embodiment”* (1991). The fact that what can be perceived are the smallest body fragments once again has allowed people to see the body as fragmented, as a supplier of the needed materials and as physiological (collection of physiological fragments) entity. Therefore, the processes of disassembling and fragmenting the human body initiated with the anatomical dissections have been continued by the visualizing technologies. Braidotti points to that when she writes that the *“greater power of vision”* is responsible for *“the unity of the organism”* to be *“dissolved into smaller and smaller living parts”* (1994:67). Anne Balsamo (1996:5) also emphasizes the same, writing, *“A range of new visualization techniques contribute to the fragmentation of the body into organs, fluids, and gene codes (...)”* and *“(…) fractured into functional parts and molecular codes (...)”* (1996:5).

Furthermore, already quoted Newman (1996) stresses that it is precisely the *“new visual technologies of high medicine”* that are responsible for dividing what before could not have been divided. What she has in mind is the introduction of the division between women and fetuses, but I would also apply this reasoning to the division between women and embryos. This particular split has resulted in the situation when only embryos appear and as such they can be seen as ‘not-belonging-to anyone’. Consequently embryos can facily be taken for objects. Certainly, visual technologies may be seen as those that initiated such division. In addition, as Braidotii (1994) sees it, they can also be charged with responsibility for creating the autonomy of what gets visualized. She writes that, *“(…) these visual techniques give a great autonomy or independence to the object they represent. The image acquires a life of its own, distinct from anything else”* (Braidotti 1994:68). Because of that, it is

of no surprise that with the inner elements on display, which as Braidotti stresses are given particular independence or like the authors of Global Culture, Global Nature (2000:33) emphasize “*relative autonomy*” (thus I would say kind of superiority) the body ‘they come from’ can be seen as merely a supplier of the desired materials. Furthermore, it seems that when such autonomy is given to the visualized elements, they appear to be able to function by themselves as if they do not need to belong to the whole complicated corporeal system in order to exist. The authors of the already mentioned Global Culture, Global Nature (2000) refer to that when they stress that, “*(...) the cell is endowed with self-regulating properties that are central to its survival, and furthermore, it is represented as an independent entity whose protective surface defends it against invasion from the outside*” (Franklin, Lury, Stacey 2000:38, 41). They also quote Emily Martin, who points out that, “*(...) in earlier time, the skin might have been regarded as the border of the individual self, now these microscope cells are seen as tiny individual selves...(...)*” which, as they put it, are “*(...) invested with an almost human motivation or agency (...)*” (Franklin, Lury, Stacey 2000:41). Visual techniques are able to give an autonomous status to the represented objects. When an embryo is made visually present and autonomy is bestowed upon it, it appears to not belong to anyone, to exist by itself, to not need a female body to be able to exist and grow. Due to that, I would argue that the embryo can be very easily seen as a surface for scientific inquiry and an object of scientific interest, whereas the organic unity of the body as neglected, useful only as long as it can supply the needed materials. Thus, what becomes visualized can obtain the status of a separate object and at the same time, the whole body (female/male) may be perceived as of no importance whatsoever. Vision is a divisive and separating entity.

I have already said that with the invention and development of techniques enabling visualization of the inner body organs, systems and the tiniest components, the accessibility of the body has been significantly increased. Nowadays, due to the implementation of medical imaging and media technologies in the field of medicine, any part of the body can be scanned and examined, and the smallest components of the highly complicated body’s system can be analyzed. The parts and dimensions of human corporeality, which before could have only been accessed when operations or post-mortem dissections were performed, have become reachable due to the

application of these new techniques. More importantly, however, the elements and components of the human body whose existence was not realized could have eventually been 'discovered'. Balsamo makes it very clear when stressing that, "(...) *the application of new visual technologies-such as laparoscop-literally bring new social "agents" into technological existence*" (1996:83). Newman also refers to that emphasizing "*Highly technical skills and complex instruments (...) make "visible objects and relationships which were invisible"- and which cannot be judged against a perceived real*" (1996:14). It is enough to mention that the egg cell, spermatozoid or embryo would have never been seen if it had not been for these new visualizing technologies. Braidotti points to this when she says that, "*We are moving beyond the idea of visibility, into a new culture of visualization; thanks to ultrasound techniques the invisible itself can today be visualized; that which the naked eye does not even begin to grasp can be the object of imaged representation*" (1994:68). But at the same time, it is not surprising that the embryo can easily be associated with an object mostly because something that has always remained invisible, thus in a way unknown and unfamiliar, is suddenly brought into view. Therefore, to associate the image of the embryo or the inner body element with an object does not require much effort. Furthermore, these kinds of associations may also be fueled by the fact that what is seen cannot be compared to anything, and as such recognized. Braidotti refers to that writing, "*Under the imperious gaze the living organism, reduced to an infinitely small scale, lose all reference to the human shape and to the specific temporality of the human being*" (1994:47). Moreover, the embryo can be taken for an object by the very fact of its becoming visualized. Sarah Franklin and Celia Roberts emphasize that embryos have become "*iconic objects*" indeed (Franklin, Roberts 2001).

Due to the above descriptions, a few important conclusions can be drawn. First of all, the medical approach that I have discussed in The Peculiarity of Medical Field can be defined as conditional for the employment and application of new visual technologies. Secondly, it seems that the images of the inner body elements and the body fragments (egg cells, spermatozoids, embryos) appear and sensations of the human body as fragmented, reduced, turned into object and material's supplier are evoked due to the utilization of new techniques in the medical field. Thirdly, it is

because of new visual techniques that the invisible becomes visible, and as such, can easily be taken for an object or a surface of scientific interest. Knowing that visual techniques make the production of the inner body parts possible, that they enable visualization of invisible and unrepresentable (Braidotti 1994:68), and that they are responsible for the certain sensations, I want to conclude that it is precisely because of the new visual techniques that images and sensations of fragmented, reduced, neglected, object-like bodies and embryos can appear. In this sense, I can also contend that the concepts of IVF, when visually established, owe much to the medical imaging and media technologies.

Visual Technologies and Assisted Reproduction

The peculiarities of the medical field and visual technologies have to do with certain presently (2008) circulating visual representations and concepts of IVF. Is it also a fact that assisted reproduction is based on visual techniques responsible for that?

I have already mentioned that nowadays many medical treatments are based on visual technologies. Assisted reproduction is no exception. IVF is conditioned and can only be performed due to the application of visual techniques that have become intrinsic components of this medical procedure. To be more precise, it was because of the introduction of visual apparatuses in the medical field that the development and performance of IVF could happen in the first place. Merete Lie emphasizes this writing, *“New technologies for looking into the body and studying the tiniest parts of it through electron-microscopes have been developed in parallel with assisted reproductive technologies-the latter would not have been possible without the former”* (Lie 2006:7). During the performance of IVF, the utilization of the medical imaging technologies in conjunction with the media technologies is, as I have emphasized, crucial though the aims for which they are used differ significantly. Interestingly enough, before IVF is recommended, many tests and examinations are performed and the process takes quite a long time. This is done in order to map out the possible reasons that couples have remained childless.

The Visual Examinations/Operations Prior to IVF

In order to map up the causes of infertility, many examinations involving the utilization of visual technologies are pursued. During the time prior to IVF, what usually takes place are the following: blood and semen analyses, post-coital test (PCT), ultrasound scans of female reproductive organs, hysterosalpinography, and laparoscopy or hysteroscopy (types of endoscopy). Yet, it must be mentioned that as far as endoscopy is concerned, this method is not only used for diagnostic reasons, but also as a form of surgery performed in order to handle the causes of infertility. Even if after endoscopy natural conception may take place, in many cases the surgery still turns out to be of no help, leaving IVF as the only chance for pregnancy. Therefore, I eventually decided to refer to laparoscopy and hysteroscopy examinations/surgeries as they are frequently performed during the phase prior to IVF.

As I have mentioned, in all the medical examinations (surgeries) prior to IVF, the presence of the visual apparatuses is essential. When the blood (female) and semen analyses are done the microscope enables observation, assessment and evaluation. This is also the case when the post-coital test (PCT) is performed. The blood test is necessary to measure the level of the particular hormones, whereas the semen is checked for its general quality. The PCT test is an examination that may reveal existing problems between the interactions of the sperm with the cervical mucus. In order to do the analysis, the cervical mucus is collected via pelvic exam a few hours after the sexual intercourse has occurred (it must take place around the time of ovulation.) The collected cervical mucus is observed via microscope to assess the condition of any sperm present. As those tests are based on the smallest elements of the human body in order to see them and read the eventual outcome, the utilization of a microscope is imperative. Consequently, what gets visualized are the tiniest bodily elements, bits and pieces. For the first scans of the female reproductive organs the least invasive method, at least as doctors see it, the ultrasonograph machine is used. It is defined as non-invasive as the probe (that emits and receives the sound waves) 'only' moves on the surface of the skin, on which a kind of oil/cold gel/jelly is spread to facilitate the passage of the sound waves. The probe can also be inserted into the body yet no surgical opening is required for the examination to be done. When the

ultrasound scans are done, as in the previous case, the very inner bodily elements are made visible. In the last two kinds of examinations, hysterosalpinography and laparoscopy/hysteroscopy respectively, X-ray technology and the endoscope are used. In both cases the possibilities of the visualization of the inner body constitute the integral part of the procedures. The hysterosalpinography test examines the uterus and fallopian tubes using the light rays and dye, called the contrast material (iodine, barium, and gadolinium), injected through a tube that goes through vagina to uterus. The woman lies on her back usually with her legs up in the stirrups and the visualizing equipment is placed above her. When the injected material spreads and flows inside making the organs more visible on X-rays, continuous pictures are taken to map its track. This examination allows the recognition of any existing abnormalities, injuries, or blockages, leaving the patient with an image of dark and white shadows of her internal dimensions. If what becomes displayed on the X-ray pictures is interpreted as a blockage or any other abnormality, laparoscopy/hysteroscopy are recommended to either bring a better explanation (diagnose) or to actually solve the problem (surgery). When the laparoscopy/hysteroscopy are performed, contrary to the hysterosalpinography test, in which the visual apparatus penetrates the body from outside with X-rays, the visual apparatus, in this case endoscope, literally 'slides' into the body in order to visualize it from inside. This 'slide', when the laparoscopy is carried through, although not considered a typical, medical operation still belongs to a rather invasive medical method, as it demands surgical opening of the body. Before the optical system, which enables observation of the internal organs in magnification, is inserted into the female abdomen, CO₂ is pumped into the abdominal lacuna to change its inner pressure and create the working/viewing space. To pump the gas a thick needle is inserted through an incision made in the woman's umbilicus. As E. Peter Volpe, quoted by Balsamo, stresses, "*(...) the abdomen is pierced to insert the laparoscope, the technological gaze literally penetrates the female body to scrutinize the biological functions of its reproductive organs*" (Volpe E.P. in Balsamo 1996:93). The hysteroscopy allows the uterine cavity to be inspected. To enable visualization of the inner body, the optical system connected to a video and the light bearing system are inserted to the female's uterus. In order to create a working and viewing space, the fluid (saline, sorbitol, or a dextrane solution) or CO₂ gas is introduced.

Both endoscopic examinations and surgeries are usually done under anesthesia. The targeted elements become visually accessible while filling in the screen with their visible presence. All the described tests and investigations are prescribed and carried out by the medial doctors in order to understand the causes of infertility, as well as to treat them, for example, with the help of endoscopic operations. The patients, generally female, are present during all the tests and examinations. More importantly, they remain so to say 'whole' and not fragmented or reduced when the investigations are carried through. Yet, because the visual apparatuses are used during those medical check-ups and because the inner body parts constitute their main target, what is eventually produced afterwards are the images of the inner body fragments. As visual technologies have the ability to fragment the body, give the visualized the status of an independent object, turn invisible into visible, make the visualized to lose its resemblance to the human shape, it is of no surprise that those images evoke sensations of the body getting disassembled, turned into a supplier of needed materials and reduced to the level of an object.

The Visual Technologies and IVF Method

When the first examinations are finalized, the decision whether to commence IVF or not is made. From this moment on, the particular conjunction between the visual apparatus and specially designed medical protocol takes place for the purpose of close and, if possible, productive cooperation. In this sense, as already said, medical imaging together with media technologies become an integral part of IVF procedure. For in vitro fertilization to be performed the female and male genetic material must be collected. In the case of a female participant, a certain number of egg cells have to be developed. In a natural monthly cycle, usually one egg is produced which is simply not enough when in vitro fertilization is planned. As doctors emphasize, to increase the chances for IVF to be successful, what is needed is a relatively high number of eggs cells. For the goal to be obtained, the hormonal stimulation of the ovaries is usually, though not in all the cases, prescribed. As doctors need to know the number and size of follicles in the ovaries, ultrasound scans are performed. With the application of this apparatus, the needed calculations and measurements can easily be done, while at the same time, the ovaries become visible. If the results are non-satisfactory either the period during which the hormones are injected is

prolonged or the prescribed medicines are adjusted to the specificity of the patient's body. When the produced visual images allow positive interpretations, the next step, the aspiration of egg cells, is advised. In some clinics this is done under anesthesia, in some not. For eggs to be retrieved, the presence of the ultrasound machine is once more irreplaceable. The result is an image of ovaries with black spots of follicles. As the aspiration is done with the help of the special needles, what gets visualized is not only the body element such as the ovary, but also the medical tool, in this case, a needle. The utilization of the ultrasound enables the observation of ovaries and follicles during the retrieval, but it also assures that the inserted needle is properly navigated and guided. If it were not for the ultrasonograph, then there would be a higher probability of an accidental puncture of blood vessels, which could lead to a life-threatening situation. In the case of a male participant, the genetic material is obtained via masturbation performed just before the planned fertilization. Yet, in certain cases when a man is diagnosed as infertile there are special techniques that can be applied in order to gather the needed material. Nowadays the following methods are exercised: Percutaneous Testicular Aspiration (PESA), Microsurgical Epididymal Sperm Aspiration (MESA), Testicular Sperm Extraction (TESE), and TESA. The use of a microscope is necessary with only one method, MESA, in order for the semen aspiration to be done successfully. However, all these advanced techniques are followed by the observation and evaluation of the semen where the microscope is needed. As after the testicular sperm extraction the layers taken out from the testis have to be searched for the sperm, the application of the visual apparatus (meaning the microscope) is absolutely essential. It almost seems unnecessary to say that what get visualized during this procedure are the tiniest body elements, which in this case means spermatozooids. Before the female and male gametes are joined, the fluid aspirated during the puncture of ovaries must be examined for the presence of egg cells. As a result the oocytes (egg cells) are made visible. The next step is the process of fertilization. The human conception in vitro may be achieved in two different ways. The first one is the so called Classical IVF, which is the most frequently exercised one. For this type of in vitro fertilization to occur, the semen and eggs are simply mixed together. The fertilization that is expected to take place is described in the medical literature as a spontaneous one. In this case the moment of fertilization does not have to be visually monitored or

observed. The situation differs when the second method the Intracytoplasmic Sperm Injection (IVF-ICSI) is performed. The IVF-ICSI takes place when the amount of sperm is significantly reduced and its quality is evaluated as relatively low. Due to that, the chances for spontaneous conception in vitro to occur are miniscule. Therefore, to make the fertilization possible, ICSI is recommended. This method involves an injection of a single sperm to one egg cell. If it were not for the invention of the inverted microscope, which makes it possible for a doctor to see both the egg and sperm, connected to the computer/video screen on which the fertilization process itself can be closely monitored, IVF-ICSI could not be performed. Here, the moment of fertilization becomes visually captured. In order to find out if the connection of gametes has resulted in the creation of embryo(s), once again, the visual apparatus gives the opportunity to find that out.

With this description the importance of visual technologies applied prior and during human in vitro fertilization can be easily recognized. The test/surgeries and IVF method are not only based on visual technologies, but in fact, their existence is conditioned by the application of those techniques. Because visual techniques are used in order to perform tests prior to IVF as well as to IVF itself, the inner body parts and fragments such as ovaries, egg cells, spermatozoids and embryos can appear and hence sensations of fragmented, reduced, object-like bodies and embryos may be evoked. Furthermore, it appears that it is indeed due to the application of visual technologies during the whole process that not only the images of the inner body fragments together with the medical tools, but also those representing the moment of conception may be produced. At the same time, because all those tests and IVF itself cannot do without the visual apparatuses that fragment the body, create visualized independence, make the invisible visible, and cause the visualized to lose its resemblance to the human shape, it is not surprising that the sensations that the body gets fragmented, turned into supplier of the needed materials and reduced similarly as the embryo to the level of an object can easily be evoked. Thus, I can say that the concept of IVF as disassembling, reducing, objectifying, turning the body into supplier of materials, making the embryo an object of scientific interest and taking the body and human reproduction under control, has to do with the application of visual technologies before and during human in vitro fertilization.

The Visual Apparatus' Encounters with the Body

Prior to and during IVF

Is it also the way the visual apparatuses work, their processes of visualization and recording that are responsible for the appearance of certain visual representations and so, concepts of IVF?

As assisted reproduction is the center of my focus, in this section I will mainly refer to the certain types of the visual machines used along in this particular process. However, as I already have said, the time prior to IVF (all test and examinations applied in order to map up the infertility causes) constitutes an intrinsic part of the patients' experience with assisted reproduction. Thus, I will refer to the used machines and the process of visualization that then take place. Furthermore, I want to emphasize that the development and improvement in the medical procedures and equipment are a constant and continuous phenomena. The amount and variety of the available medical tools and technologies sometimes do not allow the drawing of clear demarcations between them. Therefore, when addressing the applied visual technologies, I will try to approach only some while at the same time remaining aware of their enormous diversity and plurality.

The process of visualization involves the participation of the human (patient's) body, or more particularly, it's selected for the screening inner elements. It also demands a presence of visual apparatuses and of a person, inventor and operator of the applied technologies. It is crucial to recognize the occurrence of those elements when analyzing the visualization processes. What also needs to be realized is that the input of each and every component in those processes may differ significantly depending on the types of visual technologies used and the reasons they are applied.

I have already pointed out that for the blood and semen analyses, the PCT test, so to say, the finding of the egg cells (after aspiration) and embryos (after fertilization) and the performance of the IVF-ICSI method, the presence of a microscope is indispensable. For the other examinations or monitoring purposes, an endoscope, ultrasound machine and/or X-ray technology are applied. All those visual

apparatuses are made to encounter the human body in different ways in order to make it visible. It is not my aim here to explain in a very technical and detailed manner how all those machines work, yet I find it absolutely essential to address some of their characteristics. During the visualization process, depending on the kind of the visual techniques and apparatuses employed, the conjunction that occurs between the animate body and the inanimate technology is always of a different nature. For the smallest bodily elements to be enlarged, thus made observable, various types of microscopes such as light, electron, inverted or stereo may be used. However, it is crucial to mention that the electron microscope is not used during the examinations and monitoring done in assisted reproduction. Yet for the sake of the discussion, I have found it relevant to address this particular type of a visual tool as well.

The Case of Microscope

The visualization enabled by the utilization of microscopes constitutes the final stage of a rather complex process. When the microscopes are used, the invisible fragments of human corporeality placed on the glass slides or kept in petri dishes come into contact with photons (light) or emitted electrons. The moment those encounters occur, neither the body fragments nor the oncoming particles remain the way they used to be before that encounter takes place. They literally conjunct as the body fragment, the organic matter, is able to absorb those particles. In the case of the light microscopes, the photons entering the tissues, cells, etc. may simply stay in the matter or re-emerge to the surface to be focused and amplified by the lenses whose special construction gives the desired magnification. In the case of the electron microscope, those are beams of electrons that can be *“(...) absorbed or scattered by the cell's parts so as to form an image on an electron-sensitive photographic plate”*.¹⁶ Therefore, it may be concluded that what is in fact obtained, is the result of mutual transformations occurring firstly between the body fragment and the elementary particles, which further on become transformed by the particularly designed combination of lenses or special plates. To prove that those interactions and transformations do take place, it is sufficient to say that when the electron microscopes are used to observe the living objects, the moment the speeded up in

¹⁶ http://inventors.about.com/od/mstartinventions/a/microscope_2.htm

vacuum electrons hit the sample, they simply leave it dead. In addition, it is crucial to realize that different images of the same body samples can be obtained depending on the kind of the microscope used. I do not want to force my readers to get acquainted with elementary physics so to make it simple I will just repeat after my interlocutor physicist and say that with the light microscope objects that are smaller than half the wavelength of light cannot be distinguished. Therefore, if the light microscopes were used to make the tiniest fragments visible, the proper magnification and resolution would not be able to be obtained. Consequently, the observed sample would remain invisible or the image of it would be totally blurred and illegible. Anyone who deals with visual technologies will confirm that the observed organic samples and the technological devices do interact and those interactions have impact, not only on the quality and accuracy of the produced images, but also on the manners the technological tools are constructed. The organic objects may be extremely sensitive to light, temperature, etc. In order to protect them, especially when the spermatozoids or egg cells collected for in vitro fertilization are assessed, or the fertilization (IVF-ICSI) itself is performed, special conditions must be maintained. To meet those goals the inverted microscope (a different version of the light microscope) was invented. With the change in an angle that allows looking at the samples from the bottom rather than from the top, the objects can be placed in large containers, which act as a protection. Due to that, the entire content of the container can be safely observed for relatively long periods of time. Yet to enable such observations, the components of a microscope had to be particularly arranged, and those arrangements influence the produced image in terms of quality, brightness, possible magnification and uniformity. What is more, nowadays, the microscopes are connected to media devices such as: a video monitor or computer which significantly improves the conditions of observation. Due to that, the visual image of the observed matter gets transmitted and displayed on the computer screen or any monitor. Yet, for this situation to occur another specific transformation must take place. The whole process of making the living matter visible can be described as consisting of separate phases that succeed one another. Firstly the light targets the sample, then the light becomes mediated by the sample, the lenses focus and amplifies the image (yet in the physical terms the light) that is collected on the CCD (a charge-coupled device, a sensor for recording images) and transformed into electrical impulses that go to the computer

and are stored in the memory using numbers in binary code. Then, due to the utilization of the appropriate software, those numbers become converted into the electrical signals which are sent to the screen, which, in turn, can display them by transforming them into the light, taking into account the spatial distribution (on the surface of the screen) of pixels (points on the screen). Depending on the electrical signals, those pixels will turn into different colors, forming the image. Since those pixels are very small, they give the feeling of continuity and uniformity. At the same time, one should keep in mind that it is always a person (scientist, doctor, technician, trained specialist) involved in the process of visualization either as the inventor of the technology or as its major operator.

The Case of Endoscope and Ultrasound

In the case of the endoscope or the ultrasound it is respectively light and sound that encounter the examined object. When the laparoscopy or hysteroscopy is performed the light is delivered by the fiber optic cable system or together with a camera. Recently the application of a digital camera instead of the lens in the endoscope has become very common, thus it is no longer necessary to operate with additional fibre cables. In this medical procedure the light illuminates the interior of the body. Here the photons are emitted by a light source, reflected by the matter and collected afterwards by a small digital video camera. This device transforms the light into electrical signals coded in binary numbers. Those signals can be sent via a cable either straight to a video screen (when they become translated into the light) or to a computer that stores them in the memory using binary numbers. At the same time, those electrical signals can be sent to a TV/computer screen and visualized in a real time. In addition, because of the specially designed software, the images coded in binary numbers can undergo further rearrangements and adjustments. The software and skills of those who operate the machine determine the limits.

When ultrasound is performed, instead of light, sound encounters an object. The ultrasound machine transmits high-frequency sound pulses into the body using a probe. The sound waves hit a boundary between tissues (between fluid and soft tissue or between soft tissue and bone). Some of the waves get reflected back to the probe, while some go on further until they reach another boundary and get reflected.

The probe picks up the reflected waves and changes them into the electrical impulses. As in the case of a microscope, the manners, in which the apparatus is built, play an important role in the process of visualization. For instance, the shape of the probe determines its field of view, and the frequency of emitted sound waves determines how deep the sound waves penetrate and so the resolution of the final image. Equally important is the design of the probe. Some of them can be moved across the surface of the body, and some are designed to be inserted through various openings of the body so that they can get closer to the organ being examined, and getting closer to the organ can allow for more detailed views. Having received the electrical signals sent by the probe, the machine (computer) does all the needed calculations. It calculates the distance from the probe to the tissue or organ (boundaries) using the speed of sound in tissue and the time of each echo's return. When the data is processed the machine displays the distances and intensities of the echoes on the screen, forming a two-dimensional image (electronic impulses changed into the visible light) but also may store the data or image on a disk (in form of binary numbers.) In a typical ultrasound, millions of pulses and echoes are sent and received each second. The probe can be moved along the surface of the body and angled to obtain various views. In the process prior to IVF, but also during IVF, usually two dimensional ultrasound is used. Yet, sometimes three dimensional ultrasound imaging may take place. The three-dimensional images can be produced due to the specially designed software that allows 2D images to be rearranged in such a way as to form 3D images. Undoubtedly, the visual apparatus with all its constituting elements has a crucial role in the final production of a visual image. Yet, as I have indicated and what can be deduced from the foregoing descriptions, is that the observed body is, so to say, active in the processes of visualization. The point is that when the encounter between the body and light or sound that is delivered and produced (by the elements machine consists of) thus also the elements belonging to the machine itself, takes place neither the body nor light nor sound remain the same as they influence and mutually transform each other. In addition, different sorts of materials such as CO₂, chemical fluids (endoscopy), mineral oil based jelly (ultrasound), contrast (hysterosalpingography) also play a significant role in those particular transformations.

The Case of X-ray Technology

During the visualizing process that occurs when hysterosalpingography is performed, the body is scanned with light rays. The apparatus emits electromagnetic rays (photons) that encounter the body. If the rays go through the dense parts (i.e., bones) they become absorbed and so those parts appear white on the sensitive film, as the absorbed light is not strong enough to burn it. If the rays go through elements containing air they simply cannot be stopped and so are powerful enough to burn the film what results in the dark marks. The muscle, fat, and fluid appear as shades of gray because the rays are absorbed only to a certain degree. Metal and contrast media (intravenous or oral contrast) blocks almost all the photons and will appear bright white. The rays translate the body simultaneously becoming the objects of the translations themselves. Furthermore, the presence of injected contrast strengthens the translations that X-rays undergo. As suggested before, even if the contrast does not belong to the visual apparatus itself, it increases, explained already, the translating role of the body scanned with the light rays.

The Result

The analysis of the process of visualization, which as I have thus far presented as the process of constant and continuous transformations, is not complete till its result is not focused upon. What can be regarded as the final result of the process of visualization? The answer seems to be far from simple. It seems to me that the process of visualization, which is all about transformations, is a major reason for which what gets visualized does not have much in common with its original human shape. Therefore Newman's statement that "*The new visualities unhinge the referent (...)*" and that they "*(...) collapse the mimetic (...)*" seems to be a proper one (1996:110,111). If what becomes visualized cannot be compared to anything known, if the traces of the visualized, the corporeal cannot be recognized (not only because visual technologies by presenting the elements of human corporeality in the smallest possible scales make them "*lose all reference to the human shape*" (Braidotti 1994: 47) but also due to described transformations) is it actually possible to address what has been produced during the visualizing process in terms of representation?

Still, however, I find it safe to assume that if ‘something’ has been produced during the process of visualization it can be approached as belonging to the visual domain and as such, analyzed from the semiotic perspective. Therefore, in order to know what the final result of the visualizing process represents, I have decided to approach it using semiotic methods and terminology. Firstly I have concentrated on the signifier. I can say that the signifier of the visual image when displayed on the computer screen, is in fact the visible light. Previously, when anatomical illustrations were produced, the signifiers were arranged in the ways and manners the producer (a person) of a drawing wanted them to be, while at the same time they established certain concepts of the human body, as well as particular ways of perceiving and understanding the female or male body. Jordanova argues that with the illustrations of dissections’ results, “*The skill and connoisseurship of medical authors in selecting and working with artists, engravers, and printers were on display*” and because “*The author’s name and reputation was at issue: “this is really what we saw, please accept it as true”* it was really important “*(...) that the other partners in the enterprise—the artists, the engravers, and printers—were so important; it was a tacit guarantee that they had altered nothing*” (1995:203). Who or what is then responsible for the arrangements of the signifier when the process of visualization enabled by the machines is at stake? It seems to me that the visual apparatus itself, due to its particular constructions, fulfills the role once played mainly by the human. The elements of visual apparatus enable the light or sound to be delivered straight to the examined material/organic matter, collect them after they have been mediated by the organic, transform them into electrical impulses, stored in the form of binary numbers, which eventually get transformed into the visible light. Furthermore, the machine not only triggers the transformations but also conditions the final result of the process of visualization in terms of sharpness, clarity or uniformity. Additionally, contrary to sketches or drawings the targeted organic has an important role to play in the construction of the final result. The material, i.e. the body, takes a very active part in influencing the way in which the signifier eventually becomes arranged, for it is the very organic matter that absorbs or allows the light or sound to pass through. In consequence, it can be said that the signifier is constantly influenced by the particular construction of the visual apparatus, but also mediated by the targeted element of the material body. Therefore, it can be concluded that machine and body significantly

influence the final result of the visualizing process and as such become/constitute its part. At the same time, two things should be realized. Firstly, that all those transformations are enclosed within the visual apparatus itself. Secondly, that the signifier belongs to the machine being both its intrinsic element (light, electric impulse, binary code) and an effect of the manners by which it operates and functions (the continuing transformations). In this sense, once more, I can say that the machine constitutes/becomes very much a part of the final result of the process of visualization. Thus, the signifier not only stands for the perceived at the end visible light but also for the light or sound that hits the matter, the light reflected, the electronic impulse and the binary code. In addition, at a certain moment, the body becomes the very signifier as the reflected light or sound, which undergoes further transformations, from that moment on carries in itself the mark of the body. With the signifier described and defined, the signified appears to stand for the body fragment, the light, the sound, the electronic impulse, or the binary code. As the signifier and the signified cannot be in fact properly defined, it is rather difficult to discuss the final result of visualizing process in terms of what it possibly signifies or represents. Thus, once more, I want to suggest that the final result of the process of visualization represents not only the living and the organic, but equally the transforming skills of the machine and its very elements. Furthermore, I would be very prone to suggest that the result of the process of visualization should not be approached as representation *per se*. Lisa Cartwright stresses that “(...) *to study the apparatus (...) is precisely to study non-visual discursive formulations*” (2002:18). Since studying the process of visualization is actually studying the apparatus, then, as Cartwright said, I wind up studying “non-visual discursive formulations”. Due to that, it is right to assume that the result of the visualizing process should be in fact approached as belonging to the domain of those “non-visual formulations”. Therefore, I would say that to better understand the result of this visualizing process, it is important to address its ontological status. I would like to suggest that what in fact is obtained first of all stands for continuous transformations (light/sound – electronic impulse – binary code – light) triggered and supervised by the elements the apparatus consists of (lens, probe, microchips, software, computer screen/monitor, pixel (luminous point on the screen)) that themselves become part of the final result of the process of visualization. Secondly, it (the resulting visual) stands for a conjunction that occurred

between the elements (light, sound) produced by and belonging to the machine and the organic, material body part. To repeat, the result of the process of visualization stands for this specific conjunction, continuous transformations but it also stands for a temporary flash, light, electronic signal and luminous point on the screen. Therefore, I would say that what is eventually obtained is, let me use this expression, the 'merge'. In accordance with the Longman Dictionary of Contemporary English 'to merge' means, "*to combine or join together to form one thing*" (Longman Dictionary 1995:896). As I have been already able to present, during the process of visualization distinct elements such as: the organic, the constitutive parts such as: lenses, microchips, pixels, and the produced parts such as: light, sound, electronic signals conjoin at the same time forming the final result of the process. Therefore, I can conclude that the final result stands for the 'merging' thus for the 'merge' itself. Very similar conclusions can be reached as far as the result obtained during the hysterosalpingography test is concerned. In this case, the signifier can also be defined as the light mediated by the organic matter. Yet, contrary to former cases it has not been changed into electronic impulses or binary numbers. However, as in former cases it does become translated by the particular construction of the visual apparatus, meaning the sensitive film. Even if the film is not an element of the device per se, it is a part of the X-ray technology as such. Therefore, it can be said that also in this case, the final result of the process of visualization stands for the 'merge' that has occurred between the elements produced by the machine (x-rays) and organic matter. Similarly, it also stands for the processes of transformation triggered and supervised by the elements the apparatus consists of, in this case the sensitive film that itself becomes part of the 'merge'.

By realizing that during the process of visualization, due to all the transformations the body inevitably loses its reference to "the human shape", that because of all those transformations the final result of the visualizing process represents not only the body but equally the machine and the transformations that happen, and eventually because what is obtained qualifies as a product of modern, visual technologies whose production is supervised by people then there is of no surprise that eventually the living cannot be recognized and may be associated with any kind/type of an object. Anne Balsamo interestingly points out that, "*(...) visual technologies transform the*

material body into the visual medium (...) the material body comes to embody the characteristics of technological images” (Balsamo 1998:685). In a similar vein, Moore and Clarke notice that, “*(...) universal computerized representations seem to delete the body itself, dematerializing the body”* (Moore and Clarke 1995:289). Based on all the above, it appears that the way the visual machines work and the process of visualization enabled by the visual apparatus, which is all about the described transformations, are responsible for the fact that the visualized can no longer be recognized and as such can be easily perceived as nothing more than an object. In addition, I would also like to suggest that the process of making the body visible, apart from turning it into an unrecognizable surface is also a process of disassembling and fragmenting the human corporeality. In the previous parts of this Chapter I have already mentioned that the visual techniques fragment the human body due to the fact that it is the inner body fragment that gets targeted by the apparatus and that it is this very inner body element that eventually gets visualized. However, I would also like to argue that the process of visualization, during which the literal frame of computer screen or x-ray sensitive format are introduced, is responsible for evoking sensations that the body becomes disassembled and dismembered.

The Process of Recording

When the process of visualization takes place, the visualized body is present. What is seen is in a way directly connected and conditioned by the presence of the body and it can change with the slightest movement of the ultrasound probe or endoscopic camera. In this sense, the body may be seen as an active participant in the visualizing process. This happens because the body not only works as a mediator (interacting with the visual apparatus), but also as a *sine qua non* for the process of visualization to occur. Therefore, it can be said that the body, the process of making it visible and the result, happen/exist simultaneously. Moreover, the result of the process of visualization can easily be seen as a part of the visualizing process itself. As I have already made clear, the process of visualization takes place in a moment that the visualized body is present. In this sense, the visualization and its result are temporary phenomena. Therefore, for the result of such a process to gain a status of permanency, the process of recording must take place. Here I would like to find out

if the process of recording is responsible for the fact that the concept of IVF, when visually established, as a method of disassembling and turning the human body into an object, is possible to be created. It is important to mention that this does not apply to the process of visualization when x-ray technology is used. The point is that in this case the visualization process and the process of recording happen simultaneously. As I described, the result of visualization stands for a 'merge' just as in the other discussed cases, and the fragmenting takes place as the frame of x-ray sensitive film is introduced. This, however, is what differentiates x-ray visualization process from the others. The difference is that in this case what gets visualized immediately gets recorded. Therefore, I will now describe the process of recording that follows the processes of visualization enabled by the microscopes, the ultrasound and the endoscope.

In the former sections I have mentioned and proved that certain images can appear and certain sensations may be evoked due to the introduction of medical imaging technologies in medicine and the conjunction that occurred between them and media technologies. Yet the implications of this conjunction are much more than I have been able to show so far. The point is that this junction has allowed the recording of what is visualized exactly at the same time when the examinations are done. Furthermore, the improvements in media technologies, especially the fact of digitalization has enabled forms of recording that take place under the supervision of a person. This person not only makes the choices of what will be recorded, but also makes the decisions regarding what kinds of modifications and adjustments are necessary. The recording can be done in two manners. What became visualized can be recorded in the printed or as I refer to it 'saved-re-opening' form. Here, I would like to find out if it is due to this fusion between medical imaging and media technologies (because it made recording possible) and because of the process of recording itself that certain images can appear and particular sensations (body as fragmented and object-like) can be evoked.

As I described before, the computer has information of the visual image displayed on the monitor and temporarily coded in the form of binary numbers in its memory. To obtain the printed image those numbers get transformed into electric signals sent to

the printer. The type of printer conditions the nature of 'entities' into which those signals become converted. As the laser printer allows the best quality, it is the one mostly used. The electrical signals sent to the printer differently charge the drum (electrical head of the printer) and thus create a kind of an electrical image (there are no colors or light but more or less electrical charge depending on the electrical signals) on its surface. After this electrical image has been created on the drum, the drum itself comes into contact with special types of dust particles of different colors and electrical properties. Each unit of dust sticks to the surface of the drum depending on the electrical charge of each area (i.e., the electrical image) forming a real visual image with colors. Afterwards, a paper is pressed against the drum with a high pressure. The particles are made to stick to the paper under the heat produced by the laser. The dust particles on the paper are what eventually become printed out. For the image to be recorded in 'saved-re-opening' form, the temporal information of the visual image, existing in the computer memory, is permanently stored in its hard disk or 'written' on the CD or DVD.

With this description, I can state that the process of recording is the process of framing or giving a frame. When the recording results in print, it is the paper itself that constitutes the frame. The situation is a bit more complicated as far as the second manner of recording is concerned. In this case, I would say, that there are in fact three frames at stake. First of all, when permanently stored, the conversion (binary numbers-electrical signals-light) occurs in a, so to speak, a closed system (hard disk/CD/DVD-screen). This closed system can be referred to as a first frame. Secondly, because it is a screen that enables the viewing, the screen itself stands for the second frame. Thirdly, due to the application of special software, what appears on the screen can easily be changed, enhanced, modified in terms of color, brightness, and sharpness or it can also be given a proper size and shape by the employment of a particular frame. This also constitutes a one of the three frames. The introduction and the actual presence of frames have very important implications. First of all, the frame literally fragments, and as it is a fragment (part of the body) that becomes framed, the feeling of fragmentation can in fact be doubled. Yet, the significance of a frame is much more than that. To explain this further, I will refer to general visual theory. The reason for doing so is quite simple. With the reference to

the visual theory, and more precisely to George Sebastian Rousseau, I will explain the importance of the frame. This explanation will help me to argue that it is because of the introduction of the frame in the process of recording that the visualized inner part of the body can be seen as an object. Rousseau writes, *“Frames hold many things but familiarly visual image. (...) Framing assumes pictures and (...) assumes that those subjects or objects can be understood in pictorial terms through a type of translation. Frames also serve to exhibit and display picture (...)”* (2003:1). According to him frames assume the presence of pictures and visual images, thus they logically allow reading of what is enclosed within them to be done in terms of representation. This is exactly what I define as responsible for the visualized to be perceived in terms of an object. As I have managed to prove, the result of the visualization process does not in fact stand for a representation of the living matter alone and moreover, it seems it should not be approached in terms of representation as such. And yet, when the frames are introduced, what is in-between them, as Rousseau points out, can be defined in those terms. Therefore, if it is known that what gets visualized does not represent solely the organic, that in fact it is difficult to define it as representation, and yet the frames make the viewer to take it for representation and what is more for the representation of the living matter then it is no surprising that it cannot be recognized and as such can be very easily taken for and perceived as some kind of an object. Yet, I would also like to argue that the sensation that what is perceived is an object has other roots. When analyzing the recording process (working of a printer, the idea behind ‘saved-re-opening’ form), it seems proper to me to say that the process of recording, is in fact the process of creating objects. Let me briefly explain. As I previously said, the recording can be done in two manners in printed or ‘saved-re-opening’ (hard disk, CD, DVD) form. In the first case, the paper stands for an object. In the second case, the object would be the material used to save (hard disk, CD, DVD) but also to ‘re-open’ (computer), what has been saved. Therefore, it is not too much to say that with ‘them’ the image becomes an object as well.

To summarize I find it proper to say that the process of recording directly and the conjunction between medical imaging and media technologies indirectly (as this fusion made the process of recording possible) are responsible for producing

images/sensations of a fragmented but also object-like body when the visual medical images appear. As a result, I would like to conclude that the concept of IVF (when visually established/based) as the fragmentation and transformation of the human body into an object and the effect is fear of bodily dispossession and hence fear become possible precisely due to these two processes of visualization and recording.

Interests, Power and 'Reproductive' Representations

Certainly, I can say that the particular images may appear because the inner body fragments have always been used to communicate medical knowledge. Furthermore, appearance of certain images is enabled by the conjunction that has occurred between medical imaging and media technologies. This particular junction makes such images possible not only because it enables processes of visualization of inner body and of recording, but also because it allows dissemination and proliferation of what gets visualized and recorded. In this sense, the discussed conjunction can be seen as responsible for the very fact that those images are produced and proliferate. In addition, as assisted reproduction is based on the application of visual technologies, the extensive visualization occurs throughout the whole procedure. Thus, the basis for production and circulation of images gets 'naturally' created. Yet, to even more deeply understand why the discussed visual representations of IVF appear, is to comprehend the motives that lay behind their eventual appearance.

When examinations and tests prior to IVF are done, as well as when IVF itself is performed, for the diagnostic, monitoring and evaluative reasons no recording of what becomes visualized is necessary. In the daily reality of IVF the machine has mainly one aim, to enable the accomplishment of the applied methods. The reasons for which visualization takes place are strictly defined and the possibilities to see are purely for medical use. To give an example, it is enough to say that with some tests such as blood, semen analyses or PCT tests, the doctor's encounter with what got visualized is sufficient for the assessment to be made. The situation is very similar to the one when the endoscope or ultrasound is applied. In those two cases, what is seen on the monitor can be recorded without difficulty. Yet, as the monitor enables observation of the inner body, recording is not necessary for assessment or for any kind of monitoring. Therefore, for purely medical reasons, recording and

proliferation of what gets visualized prior to or during IVF is not really required. However, without doubt IVF represents a very revolutionary procedure as it enables something previously unimaginable, such as human conception in vitro. According to Ludmila Jordanova, *“the theme of display bears an important and complex relationship to medicine (...)”* (1995:203). She argues that in the eighteenth and early nineteenth century, the medical field became scrutinized and widely criticized. As a result, those associated with medicine had to display the safety and sufficiency of their applied methods, but they also had to make people trust them again. Doctors *“displayed their educational qualifications and their links with learned patrons and teachers (...) they displayed their institutional affiliations with colleges and learned societies; some of these institutions exercised genuine power over the profession, and all attempted to exercise cultural control through the display of portraits and commemorative medals of their most famous men (...) [they] displayed their scientific knowledge, clinical expertise, and professional probity in periodical publications (...)”* (Jordanova 1995:206).

Knowing the origins of this ‘tradition of display’, I would say that this very tradition is constantly maintained and well settled in the landscape of medicine. Thus, I want to argue that the visual representations of IVF (the images of interior design of fertility clinics, of people in labs, of inner body parts, of inner body fragments and medical tools, of the moment of conception, of embryos, and the unrecognisable images) circulating nowadays fit very well into this medical ‘tradition of display’. It is not surprising then that something so revolutionary (IVF) wants to be put on display and that the power of new medical procedures, of doctors’ skills, beauty of invention, and the promise given by advanced technologies want to be demonstrated and represented. Yet, it should be remembered that nowadays IVF is mostly offered in private medical centers that gain profit with every test done and every IVF cycle performed. Thus, I want to contend that IVF gets visually represented in order to display excitement and demonstrate knowledge and qualifications, but also to sell the method.

In order to share excitement, demonstrate scientific knowledge, doctors’ qualifications, and to sell the offer, the cause of the excitement must be presented.

The excitement undoubtedly comes from the possibilities of performing fertilization *in vitro* and obtaining embryos. Franklin and Roberts (2001) addressing pre-implantation diagnosis, (PGD) a procedure offered in the UK to test embryos for specific genetic conditions, emphasize that embryos are “(...) *the most ‘highly valued’ objects in the clinic (...)*” (2001). They also write that the embryo “(...) *is a sociomaterial actor existing within a broad set of technical and social practices. Within particular technical scientific and biomedical practices-those of embryology, cytogenetics and assisted conception-under the microscope and within clinical discussions, it is literally centered as a sociotechnical object. Practices constituting the technoscientific and biomedical aspects of IVF-egg and sperm collection, ICSI (...), embryo culture, embryo freezing, and embryo transfer-are all focussed around the production and preservation of ‘good’ embryos. The embryo, it might almost seem, is everything*” (Franklin and Roberts 2001). Thus, it is not surprising that embryos appear to such a great extent in the visual materials. Furthermore, as assisted conception is about joining female and male genetic material in vitro, performing fertilization in vitro, and creating embryos in vitro then the images of the genetic material and the moment of fertilization are obviously the images to present in order to share the excitement. At the same time, I would argue, as the cells, as the moment of fertilization in vitro, as the embryo, all create the scientific excitement, there is therefore no need to visually display the couples they belong to.

Furthermore, to share excitement, demonstrate scientific knowledge, doctors’ qualifications, and to sell the offer, the cause of the excitement must be also well explained. Jordanova emphasizes that, there is “(...) *no place for uncertain (...)*” and that “(...) *display requires that the abstract and processual be translated into a visible and frozen form, easily seen and apprehended*” (Jordanova 1995:211). For IVF to take place, not only the application of certain medical protocols and technological tools is needed, but also the presence of the person who literally does the job. Thus, to describe IVF procedure, the participation of a person must be addressed. In consequence when the images get displayed, what can be seen is the active share of doctors and different technicians in the performance of the IVF method. What is more, as this method is applied to, hopefully, achieve successful fertilization followed by pregnancy, images showing this very moment of the

spermatozoid being inserted to the egg cell appear. In daily life practice of IVF the most frequently practiced is Classic IVF (egg cells and spermatozoids mixed together). However, this fertilization does not get visualized. Yet, as IVF is a method enabling conception, the moment fertilization occurs must, somehow, be visually represented. To accomplish this, images created during the application of the very specific method IVF-ICSI are used although this technique is usually only recommended due to specific medical indications. Moreover, as the IVF technique is conditioned by the collection of and based on the conjunction of female and male genetic material, in order to describe that, this very material becomes displayed. Furthermore, as the IVF procedure starts with ovarian stimulation, followed up by egg retrieval, and ends with in vitro conception, respectively the images of growing follicles, of eggs' retrieval, egg cells, spermatozoids, and those of fertilization get presented. For the method to serve its descriptive purpose there seems to be no need to represent the bodies of the patients. For the same reason, it is not necessary to show images referring to the examinations/operations done prior to IVF although the time during which they were done, in fact, constitute *sine qua non* for IVF to be eventually recommended and applied.

Referring to Jordanova's (1995) discussion regarding medicine and different genres of display, it seems that the visual representations of IVF fit very well into the described medical 'tradition of display'. The medical field has always been interested in communicating knowledge and qualifications, and nowadays, in the era of commerce, it is equally concerned with its financial state. Thus, I can say that it is precisely because of those factors that contemporary representations of IVF are what one may see. Due to that, IVF appears to be all about technological supremacy, human reproduction, bodies, and embryos under control, fragmented, reduced and objectified human bodies. In addition, this medical procedure may also seem to be short in time, easy, successful, physically and emotionally non-demanding. Moreover, it appears that when IVF is applied, reproduction is what only matters, bodies are no longer needed, there is no pain, and the tools and machines are sufficient enough and the only necessary to 'pass' the human life on.

Addressing the feminist's analyses which point to the fact that behind every representation are certain interests, what in case of IVF would be, among others, to make the method socially accepted and tame its revolutionary potential to attract potential patients, I want to find out if those have anything to do with contemporary visual representations of IVF. Franklin (1995) and Lie (2006) both emphasize that the moment assisted conception is presented the reference to natural reproduction is made. Lie also stresses that, "(...) *new technologies are being talked about in casual and familiar terms (...)*" (2006:7). The 'naturalisation' of technologies is done in order to make "*these new technologies acceptable and familiar*" and to transform them "(...) *from something strange and unknown into something useful and familiar*" (Lie 2006:6, 7). As IVF wants to be 'made' as 'natural' as possible, it is not surprising that eggs and sperm appear and the moment of their conjunction is visually represented and is spread throughout the public sphere. Furthermore, for technologies to be accepted they must appear as easy to perform, painless, successful and secure. As a result, representations are constructed in certain manners as to deliver the required assurance. Thus, I can conclude that it is because of those interests that the concept of IVF as easy, successful, paralleling nature and maintaining heterosexuality medical procedure can be easily established.

Furthermore, according to the feminist's analyses, the female bodies have been pictured in such a way as to confirm the docile, subordinated, passive nature of women attached to the domestic sphere, family values, reproduction, and so motherhood. (Newman 1996; Joradnova 1989; Martin 1991; Stabile 1998; Tuana 2004; Moore and Clark 1995; Groneman 1995). The female bodies have been described as reproductive, yet it has been the fetus that has gotten priority. The body of a woman is supposed to deliver a baby and her body matters only if it manages to do it. Thus, when it comes to reproduction, female bodies somehow always fall out of the picture and the fetus takes all the space for itself. (Franklin; Newman 1996; Stabile 1998; Petchesky 1987; Hartouni 1998). These types of representations are not changing and are nowadays facilitated by the new visual technologies "*Feminist commentators have repeatedly observed that (...) fetal imagery [currently also embryo imagery]*"¹⁷ (*from high-tech medical images*) *effaces women's reproductive*

¹⁷ Emphasis added.

bodies. In feminist accounts, the image of solitary fetus and the erasure of woman's body demonstrate certain set of social relations in which women and their bodies are subject to men-a paradigm more or less complicated by other categories, such as race, class, and/or historical context" (Newman 1996:8). Furthermore, the moment of conception is pictured in such a way as to show the female as passivity and the male as activity, for example, the egg peacefully waiting for a brave, fighting, and doing sperm. (Martin 1991). It has also been described visually, among other things, as a love story, the connection between woman and man, and so a heterosexual event per definition (Lie 2006). Stabile interestingly points out that, "biological reproduction is reduced to the contribution of genetic material (...) the female body is reduced to a single passive ovum that waits patiently for her rendezvous" (Stabile 1998:189). However, as some feminists argue, those images are not "(...) static entities that appear to stand outside the chaos of social life" (Jordanova 1989:149). They are always invested with meaning. They are "saturated by all sorts of contingencies: perceptual, temporal, historical, ideological" (Newman 1996:4). They are not neutral and objective but have stood for the expression of certain ideologies and beliefs regarding femininity and masculinity. Jordanova stresses, "(...) gender together with the biomedical sciences of which it was an integral part, expressed and informed cultural processes" (1989:159). Thanks to those representations, the norms of what feminine and masculine should mean have been confirmed, the (gendered) social roles of woman and man secured, and heterosexuality made the major pattern and style of living to follow so to maintain the most welcomed and desired social order. Knowing the general manners of addressing bodies when it comes to reproduction and reproduction *per se* and what stands behind them (power relations), should one be surprised that the visual representations of IVF follow a very similar pattern? Lie (2006) herself, when referring to Martin (1991) asks "(...) to what extent they [pictures of the egg and sperm connection]¹⁸ reflect common perceptions of the egg and sperm and the romantic story of their fusion" (Lie 2006:7). It seems to me that it is precisely because of the unchanged ideologies and tradition of discussing those issues, that the present day visual descriptions of IVF are the way they are. Balsamo emphasizes that, "(...) biotechnologies are ideologically 'shaped by the operation of gender

¹⁸ Emphasis added.

interests' and (...) serve to reinforce traditional gendered patterns of power and authority" (1998:686). Furthermore, such representations can also make technologies more acceptable as they assure that the social order, roles, norms, and values will not get changed. Thus, again, female bodies exit the picture (Mentor 1998; Shanner 1998; Balsamo 1996). The eggs and sperm and their connection take priority (Franklin, Lury, Stacey 2000; Franklin and Roberts 2001; Lie 2006). The sperm is being injected to the egg cell and embryos as fetuses appear as solitary agents (Stabile 1998; Franklin and Roberts 2001).

Conclusion

The visual representations of IVF in popular mass media, such as the Internet, conceptualize human in vitro fertilization as an expression of technological supremacy and power. Furthermore, the whole procedure seems to be simple, easy, predictable and successful. IVF also appears to stand for the process that parallels 'natural' processes and promotes heterosexuality. What is more, in vitro can be seen as a procedure that turns human bodies and reproduction into a strictly controlled phenomenon where reproduction is all that matters, where tools and machines do the job, where bodies are no longer needed, where there is no physical and/or emotional pain, no hardships, no challenges and no joy. In addition, visual representations conceptualize human in vitro fertilization as a procedure that disassembles fragments, reduces, neglects and objectifies embryos and the human body becomes nothing more than the supplier of needed materials.

As I have presented in this Chapter, those representations (the images of the interior design of fertility clinics, of people in labs, of inner body parts, of inner body fragments and medical tools, of the moment of conception, of embryos and the unrecognizable images) and conceptualizations of IVF are conditioned by the practices intrinsic to the medical field, the application of medical imaging and media technologies in the medical field, the specificity of visual techniques *per se*, medical 'tradition of display', power relations and patterns of visually discussing human reproduction and by the interests of those who want to advocate IVF. Therefore, I conclude that it is a particular construct, a made-up image of IVF that is circulating in the visual mass media. In this sense, the concept of IVF that emerges from its

current visual descriptions does not qualify as an accurate one. Furthermore, the interests of those who want IVF to operate on a wide scale are involved in the production of particular representations. Those representations should be approached with a significant amount of doubt. I do not wish to say that the visual representations of IVF are not reliable sources of information concerning the very method itself, and i.e. how it is done, but I want to argue that it does not provide a viewer with the 'full picture' and does not allow people to really 'grasp' and to understand what human in vitro fertilization is all about. Thus, I would say that the viewers who want to formulate proper assessments of/concepts of/approaches towards human in vitro fertilization should be very careful when choosing contemporary visual representations of IVF as a way to do so.

Rosi Braidotti says that there is a belief that *"(...) visibility and truth work together"* (1994:69). Yet, it seems that this is not really so and therefore representations simply 'cheat' as *"there is always something more to the experience than the image can show"* as *"there is always more to things than meets the eye"* as *"there is no adequate simulacrum; no image is a representation of the truth"* (1994:69). Braidotti is right. She is right because the discussed representations and concepts result from certain processes and so stand for particular types of 'constructs'. Thus, the concepts do not classify as accurate ones and representations cannot be seen as providing the full spectrum regarding IVF. But Braidotti is also right because, due to those processes, 'much' is left out. In Introduction, I have emphasized that I will address the application of visual techniques prior to and during IVF also to show the discrepancy between what really 'happens' and what becomes eventually represented. There are bodies, 'whole' bodies along the whole process, there are difficulties and obstacles, there may be physical and emotional pain, people waiting for the results of fertilization in vitro, joy when the fertilization was a success and lots of sadness when there were no embryos obtained, no pregnancy established, or miscarriage occurred. Yet, what eventually appear are the body fragments, eggs, sperm, moment of conception, tools, machines and high-tech interior designs of infertility clinics and the concepts of fragmented and controlled bodies and human reproduction.

IVF is not offered in one clinic, in one country, in one cultural, social, political and economical setting. It is not done by one doctor/nurse/technician to one anonymous patient. The patient is not an empty space, air balloon, or shapeless form in the doctor's cabinet. The 'bodies' that undergo this treatment are embodied human subjects, driven by productive desires, undergoing constant becomings and metamorphoses. IVF does not start 'just because', but it is a part of a longer and broader procedure that has its beginning in problems with conception and whose importance does not end with an embryo transfer, but continues long after the birth of a baby or, sadly, miscarriage. Only more complete representations, representations that can capture what I have just mentioned, have chances to be reliable. Only concepts based on such representations have chances to be accurate.

CHAPTER THREE

IVF as a Situated Practice and a Part of a Longer Procedure

PART I

Situated Practice/Part of a Longer Procedure

Looking at in vitro as a situated practice and a part of a longer procedure is another way to see IVF technique and practice in ways that are more positive and accurate than those of the radical feminists and the Vatican.

Dion Farquhar emphasizes that, “*the distinction between “the technologies themselves” and “the power relations within which... [they] are applied...,” preserves its characterization as a thing and denies its flexibility, its historicity, and its status as a practice*” (2000:210). In accordance with English dictionaries, ‘practice’ indicates an action, something that is done. IVF practice means organization and performance. With the term performance, I refer not only to the behaviour/actions of medical staff, but also to the manners in which the technique is exercised and to what the doctors do with technology. To me, IVF definitively stands for a particular medical technique yet every time it gets applied/implemented/organized/performed it becomes a practice. IVF technique becomes a practice by the fact of being applied/implemented/organized/performed together with the introduced laws, general directives and general arrangements. However, IVF is practiced in various places/countries thus, how it is applied, the types of laws, kinds of directives and arrangements (i.e. the organization and performance itself) are all influenced by different factors. These include, among others: culture, existing ideologies, religion, economic, political situations and decisions. Therefore I want to emphasize that these factors do influence the final form IVF practice may take. To say it differently, the particular shape of IVF practice is a result of, and is conditioned by culture, economical factors and certainly political moves that actively participate in the making and shaping IVF practice. Saetnan (2000) when presenting and discussing different views concerning technologies (determinist views, social shaping view, structuralist theories and constructivist approaches) stresses that new conceptive techniques such as human in

in vitro fertilization techniques are always influenced by the cultures they encounter. She writes that, “Technologies do not arise in social vacuum” and that “They are the products of social processes and social choices (...) Thus we may see technologies as being “socially shaped” (Saetnan, 2000:3). Furthermore, IVF technique becomes a practice together with the internal directives, arrangements and policies of the medical centres. Yet, those types of directives/arrangements also result from certain factors. They represent the outcomes of the doctors’ decisions, but equally economical settings, and the cultural and political climate. In addition, IVF is also particularly located in time, meaning it is a part of a longer procedure.

Situated Practice. Human In Vitro Fertilization at the National Level

The Netherlands

Prof. Bart C.J.M. Fauser from the Dutch hospital UMC/AZU, emphasizes that in the Netherlands, all types of advanced medical procedures are practiced in hospitals. Although Dutch hospitals have a relatively high level of freedom in setting up their care policy, they remain under close quality supervision exercised by the Health Care Inspectorate acting on the behalf of the Dutch government. In terms of finances, hospitals cooperate with the insurance companies, which basically mean that they have the right to claim the money for the offered services and the companies are obliged to pay them. This system apparently works as all Dutch residents are obligatorily insured. This obligation was introduced with the new Zorgverzekeringswet (The Health Care Insurance Act) that came into effect in January 2006. With this Act, the division between public and private insurance was annulled. As a result, the new health insurance system became privatized, operated by the private health insurance companies. The new insurance “comprises a standard package (to which every resident has rights) of essential healthcare, which provides essential curative care tested against the criteria of demonstrable efficiency, cost effectiveness and the need for collective financing” (Zorgverzekeringswet 2006). Even if the system is a private one, the governmental, thus public, control is still present as it is the politicians who decide what the basic insurance package must contain. Furthermore, in accordance with the Act “the insured has to pay a nominal premium to the health insurer and everyone with the same policy pays the same insurance premium” (Zorgverzekeringswet 2006). The

Act also “provides for an income-related contribution to be paid by the insured. Employers contribute by making a compulsory payment towards the income-related insurance contribution of their employees” (Zorgverzekeringswet 2006). As a result, every Dutch resident, when in need of hospitalization, may use services offered by hospitals and the insurance companies will cover the cost. Yet, which costs will be covered and which not depends on the kind of the insurance the prospective patient is insured with. My point is that the basic package comprises only certain types and numbers of tests, examinations or treatments for which the costs will be covered. Therefore, if the consumers/patients want other kinds of medical services to be reimbursed, they must purchase a more expensive insurance package. From what I have said till now, it appears that in the Netherlands for human in vitro fertilization to be practiced and reimbursed, it must take place in a hospital. This is exactly what happens. IVF is offered in hospitals and thus covered by the insurance companies. In the standard package with which all the Dutch are obligatorily insured the three IVF attempts are reimbursed.

As Prof. Fauser explains, in the 1980’s the Unified Board of Insurance Companies decided that there was a desire to recognize and pay for IVF though under certain conditions. Human in vitro fertilization, as several other applied medical methods, was seen then as a special and rather experimental technique. Therefore, the insurance companies agreed to reimburse IVF only if an adequate registration of the method was introduced. Furthermore, the number of medical centers offering IVF was asked to be precisely defined. It is interesting to notice that since 1988 their number has not changed as no increase has been allowed. Moreover, IVF had to be recognized as a type of medical therapy. From what Prof. Fauser says, it appears that the existing, international approach towards fertility problems helped this to be accomplished. As I have said previously the World Health Organization has defined infertility “(...) as a failure to conceive following 24 months of normally frequent unprotected sexual intercourse” and health “(...) as a state not only of physical well-being but also of mental and social well-being” (Dickens 2001:344, 335). Because infertility was acknowledged as negatively influencing the mental well-being of those having problems with spontaneous conception, the United Nations explicitly stated that they were entitled to “(...) the right of access to appropriate health-care

services that will provide couples with the best chance of having a healthy infant” (Dickens 2001:335). Because in vitro fertilization can certainly be described as a method of overcoming fertility problems, in 1986 in the Netherlands, it was recognized as a type of therapy/treatment. The Health Council of the Netherlands, which was asked by the government for advice on IVF, was responsible for this recognition (Kirejczyk 1994:155). Dr. J.M.D. de Waardt of the Dutch Ministry of Health states that in the Netherlands, *“the doctors put the indication for a medical treatment”*. Thus, because these doctors held the majority position in the Council, it seems accurate to conclude that they (the doctors) were, in fact, responsible for the official recognition of IVF in the Netherlands. Yet, it must be kept in mind that this recognition resulted from certain actions that were undertaken. Kirejczyk, in her article addressing the IVF practice in the Netherlands writes, *“In 1986 the Health Council issued its second report (...) In this report, which covered a broad range of the medical, organizational, social-psychological, ethical and juridical issues, it extended its scope. A new term, ‘artificial reproduction’, was introduced to cover a heterogeneous collection of issues and techniques: highly sophisticated and controversial medical procedures such as IVF and egg-cell donation, a simple, nearly do-it-yourself and socially fully accepted technique of artificial insemination by donor (AI), and the controversial but marginal social phenomenon of surrogate motherhood. In this way the impression has been created of the common nature of the issues involved in IVF, AI and surrogacy. IVF-technique was now clearly defined as a medical treatment of female infertility (Health Council, 1986)”* (Kirejczyk 1994:155). However, as Prof. Fauser says, it appears that if IVF had not been defined as a medical therapy it would not have been located in hospitals. What is more, if IVF had not been qualified as a type of a treatment and located in hospitals it would not have been reimbursed. Therefore, Kirejczyk’s remarks that in the Netherlands IVF’s *“conceptualization legitimized the introduction of IVF to the health service”* and that *“the status of IVF is of considerable importance for its social acceptance and for the provision of funds”* (1994: 156, 155) adequately illustrates the birth of a particular type of IVF practice in the Dutch settings.

All the mentioned decisions were followed by other debates and resulting from those legal regulations, such as those concerning sperm donation (Wet donorgegevens

kunstmatige bevruchting 2004) and the status of the created embryos (Embryowet 2002). As far as sperm donation is concerned, in order to diminish the risks of marriages between children that have been conceived with the sperm of the same donor, it was decided that their total number could not exceed twenty-five. This consensus was reached by the Dutch professionals in 1992 and accepted by the government (Janssens 2003). In June 2004 another law, this time concerning sperm and oocyte (egg cells) donation, came into force. With its implementation the period of anonymous donations was terminated. The idea of removing donors' anonymity was proposed by the religious political parties in the 1980s. In 1993 the first, and in 2001 the final draft of the proposed law was sent to Parliament (Janssens et al 2006). Before, the law was implemented, numerous political and public debates and intense media pro campaign such as: “(...) *coverage by [television]*¹⁹ *of ‘real life stories’ involving donor offspring (...) telling their stories, and a popular, moving, regular television programme about (almost always) adopted children searching for their biological parents (...)*” had taken place (Janssens et al 2006). In 2004, a law known as Wet donorgegevens kunstmatige bevruchting was eventually accepted. From the moment the law came into force certain information regarding the donor could be given to the child, its legal parents or a doctor upon request. However, when a doctor chooses a donor, a couple may obtain only limited information concerning her/his blood group, height, weight, eyes and hair colour as the donor's personal identity can only be made available to the child itself. According to the mentioned law, when a child reaches the age of twelve, she/he may ask for information regarding the donor's education, work, family situation and motivation for donation. When a child is sixteen years old, it can receive all personal information (name, address and date of birth) upon request. However, it was emphasized that the donor would have no responsibilities towards the children born from the donation. The legal father of a child was said to be the male partner of the woman fertilized with the donor's sperm. In the case of lesbian couples, it was decided that there would be no legal father. All donors are registered at the independent, national foundation Stichting Donorgegevens Kunstmatige Bevruchting (Foundation for Donor Data, FDD) (Janssens et al 2006). At the same time, it is interesting to mention that even if it were the religious parties that proposed the abolition of donor anonymity, still,

¹⁹ Emphasis added.

according to Dr. J.M.D. de Waardt, the Catholic clergy and the Protestant Church leaders have had very little influence on politics. As he points out, when the houses of the Parliament organized a hearing for social, health and religious organizations, the Roman Catholic Church and Protestant Church's leaders were also invited, yet they did not get special treatment. According to Dr. de Waardt the mentioned Churches may have an impact during the period when information is provided and opinions are formulated, however, they have no influence on the policy making itself.

Whereas the Wet donorgegevens kunstmatige bevruchting regulates issues of donation, the Embryowet that came into effect in September 2002, does the same in reference to embryos, which in the Act are defined as “(...) *a cell or a connected aggregate of cells with the capacity to develop into human being*” (Derckx and Hondius 2002:395). As the authors of the quoted article emphasize, “*The legislator's general point of departure is human dignity and the principle of respect for human life in general. Any violation of this principle of respect for human life is justified if other values, such as the welfare of the future child, the treatment of patients or the promotion of their health and the welfare of infertile couples, are considered to be of greater importance*” (Derckx and Hondius 2002:395). The introduced law sets limits on the uses of gametes and embryos and the “(...) *cloning, the choosing of a baby's gender for non-medical reasons and combining cells from human and animal embryos*” is not allowed (Derckx and Hondius 2002:395). Furthermore, according to this law, the genetic code of gametes and embryos cannot be changed, embryos can only be produced for the purpose of pregnancy, and the trade of gametes and embryos is forbidden (Embryowet 2002). The act allows couples undergoing IVF to donate spare embryos for scientific purposes such as production of stem cells or medical research. At the same time, it is emphasized that no payment must be involved. As far as scientific research is concerned, it is said that such research must be of medical importance. It is also stressed that, “(...) *all research programmes has to be approved by the Central Committee on Research involving Human Subjects (CCMO)*” (Embryowet 2002). According to the Act, it is up to the commission to “(...) *decide on a case by case basis whether the scientific research, and thereby a violation of the principle of human life is justified*” (Derckx and Hondius 2002:398).

As Derckx and Hondius make clear, the production of embryos strictly for scientific purposes is banned because “(...) *the objective of such activities is not to create the person, but rather to broaden knowledge (...) [what]*²⁰ *would mean a greater violation of the respect for human life (...). It is for this reason and because of the reserved societal and international views on this point, that the ban has been adopted in the Embryos Bill*” (Derckx and Hondius 2002:398).

To sum up, firstly, I want to stress that in the Netherlands because of the cultural, economical and political climate, in vitro definitely obtained the status of a regular medical therapy and so to speak, regular medicine. Prof. Fauser seems to agree with such a conclusion saying, “*Here, I think, IVF has become a regular medicine whereas everywhere else is an exceptional medical practice directed only to those who can afford it, what usually means the very wealthy people.*” Furthermore, due to the cultural and political factors, IVF technique in the Netherlands became a controlled, monitored and reimbursed practice where donation is safe and where the rights of the child as well as those of embryos are respected. With the abolishment of donor anonymity “(...) *the wish of offspring prevails above others involved*” (Janssens et al 2006). Because of that, IVF practice in the Netherlands can be seen as putting the child’s interest first. Furthermore, with the introduction of the Embryowet it seems possible to define IVF practice in the Netherlands as protective towards embryos created during its application. The number and location of IVF clinics was clearly defined, the need for statistics to be made visible was expressed and financial issues were addressed. The centers’ quality and efficiency can easily be verified. On specially designed web pages ([www.nvog.nl/patientenvoorlichting/IVF Resultaten](http://www.nvog.nl/patientenvoorlichting/IVF%20Resultaten)), the results of the application of IVF technique from all the medical centres in the country are available. The percentage of commenced cycles, ovary punctures, embryo transfers, pregnancies, types of pregnancies (single, twins, triplets), pregnancies resulting in birth when respectively IVF, IVF-ICSI, or Cryo (transfer of previously frozen embryos) has been applied can be checked. In the Netherlands, because of the decisions made, IVF technique has become relatively safe, transparent, accessible in terms of information and affordable practice. What is more, as IVF practice is situated in hospitals among other medical departments, as the

²⁰ Emphasis added.

previously mentioned Prof. Fauser says, it is not perceived as exceptional or unique but rather similar to the other regular medical practices. The location in hospitals also allows it to be seen as a type of medical help, another way to overcome gynecological/medical problems. Furthermore, because it is reimbursed, IVF practice can avoid connotations with a commercial, thus possibly commodifying practice (the fact of being located in a hospital only adds to that.) To sum up, I want to emphasize that in the Netherlands, IVF technique has been turned into a controlled, supervised and monitored practice that is reimbursed, relatively safe, transparent, affordable, and as such, accessible.

Poland

In contrast to the Netherlands, problems with fertility and spontaneous conception have not been seriously discussed in Poland. According to Dr. Zbigniew Zalewski, the bioethics and philosopher of medicine at the Jaggiellon University, Krakow, Poland, from the Polish medical perspective, fertility problems are seen as a certain type of health impairment and as such should be cured. Yet, as he emphasizes, the fact that in Poland those issues are not seriously addressed and publicly debated is the outcome of the general cultural approach. The point is that human sexuality is still a taboo in Poland. Because the conception of a child is inevitably linked to the sexual domain of human life (a taboo) everything that remains close to this zone, such as fertility problems, becomes immediately classified as a taboo, as well. Since they are taboo, sexuality, fertility and infertility are not classified as 'decent' enough to be made overt and worthy of public debate. As a result, the new methods that can be applied in order to overcome fertility problems such as IVF method, have not been seriously addressed either. Not considered important and classified as a taboo, both issues of infertility and methods of handling them have not been adequately debated on the governmental level. It is not an exaggeration to say that the official position of the Vatican is highly responsible for this situation. The Vatican approaches sexuality in the terms of an intimate and private matter, which should be left out of the public sphere but also criticizes human assisted reproduction. In Poland, the Polish Catholic Church is a very influential institution. Because it remains closely linked to Vatican policy, thus also to its objections to IVF technique, the general Polish rejection of IVF as an accessible medical method has become

understandably, a reality. The Vatican's rejection transmitted through the Polish Catholic Church became binding for many politicians and doctors. A significant number of policy makers recognize this negative position and the real influence of the Polish Catholic Church acting on behalf of the Vatican on both politics and society. The former government's Commissioner for the Affairs of Equal Status of Women and Men, Izabela Jaruga-Nowacka emphasizes that the Church's attitude towards IVF technique is responsible for the fact that infertile couples are left on their own (Tomczak 2004). In this sense, Poland is a very good illustration of the discussion led by Bernard M. Dickens. In Ethical Issues Arising from the Use of Assisted Reproductive Technologies (2001) he emphasizes that as far as new reproductive technologies are concerned *"different popular religious attitudes to relations between human beings and their perceived divine creator can influence policy responses to ART. In many Christian communities, for instance, it is considered offensive and a condemnation that one should assume to "play God" with human conception and birth, as an impertinent human arrogation of divine power and authority. Accordingly, social policy treats the practice of ART conservatively as bordering on impropriety, and detracting from or tampering with the awe and humility with which to face divine authority"* (Dickens 2001:338). As Dr. Zalewski points out in the 1980's, the first research on human assisted reproduction, which then remained in the sphere of medical experiments, was initiated and funded by the public budget. However, during the 1990's, after the fall of communism, research on IVF technique was withheld together with the money. In 2005, the Polish Parliament objected to the incorporation of in vitro fertilization into the public health system, simultaneously rejecting the proposal of IVF technique being funded with the public money. Only the first examinations done in order to map out the possible causes of problems with conception such as: blood and semen analyses, the ultrasound scans, hysterosalpinography or laparoscopy are funded. Dr. Zalewski makes the described cultural factors highly responsible for this decision. As it has been said, with sexuality and infertility approached as timid issues (the Vatican's influence) comes the conviction that they must not be publicly debated, addressed on the governmental level and solved with taxpayers' money. Due to that and because of the Polish Catholic Church's, following the Vatican's directives, rejection and condemnation of new conceptive techniques, it comes as no surprise

that in Poland IVF technique has not yet been seriously approached as a possible type of medical therapy. In addition, as Dr. Zalewski stresses, with the generally bad conditions of the Polish public health system there are no real chances for the situation to be changed in the nearest future. In 2005 the chances for change became even more miniscule. In that year, the parliamentary elections were won by the very conservative and ultra-Catholic parties for which Catholic doctrine was treated as binding. Therefore, infertility was not seen as a problem worth solving but rather as a type of the punishment or destiny that should be peacefully accepted. IVF technique was certainly not seen as a way to solve this problem. In 2007 the liberals came to the power, yet they are also not willing to turn in vitro into a reimbursed medical procedure. Furthermore, as the Polish Catholic Church represents a powerful and influential institution, the new government does want to maintain proper relations with the clergy. Interestingly, at the beginning of 2008, the Polish Catholic Church mentioned that it would be good to have 'some' legal frames when it comes to human in vitro fertilization. However, the Church still refers to the Vatican's document Donum Vitae (1987) that does not agree with the implementation of this method. In this document there is the emphasis that in vitro should not be approved but there is also a call for legislation that will prohibit certain elements intrinsic to this technique such as the donation of gametes, embryo banks or surrogate motherhood. In this sense, those who are more than euphoric about the change in the Church's attitude should be very aware of where such change may eventually lead. I do not want to be a 'wicked prophet', here but it can be assumed that the Church, referring to the Vatican's document, does not want to have this legal framework in order to help the prospective in vitro couples but on the contrary. I want to suggest that those possible legal frames the Church has mentioned are rather seen by it as the means to stop IVF technique from being implemented or to stop or severely restrain its practice. What implications this can have for searching for the solutions couples, one can only try to imagine.

In Poland, at present (2008) because of the religious viewpoints, political climate and decisions in addition to the economical situation, the 'IVF-issue' is still treated as not that important. No regulations regarding IVF technique have been introduced and no legal framework concerning donation or the status of created embryos has been set.

Due to the fact that no regulations concerning human in vitro fertilization have been introduced, it has become relatively easy for the Polish private medical centers to take it over. Next to them, IVF technique is also offered by clinics affiliated with the medical academies. With no regulations introduced, no legal arrangements and no defined requirements that clinics must meet, any medical institution in Poland can place IVF technique in its general medical offer without accreditation (the permission to introduce a particular method of medical practice) and function without external controls.

To summarize, I can say that even if in most of the cases doctors in Poland speak about in vitro as a medical therapy, it still appears that in the Polish settings it cannot be referred to as one. In Poland IVF technique is not recognized as a medical method applied in order to overcome particular health impairments. In Poland cultural and political factors has not turned IVF technique into a controlled, monitored and reimbursed practice with safe donation, where the rights of children and embryos are respected. No regulations, directives or legal framework have been introduced. The private clinics have used the propitious climate to take over the IVF technique. Currently there is no way to check the quality and efficiency of the services offered. The people implementing the technique, as well as the technique itself (i.e. used medicines) fall outside of any sort of legal regulatory system. What is more, as one Polish doctor, who wanted to remain confidential, told me, it was not easy to open and run profitable clinic. The doctors themselves are responsible for having and gathering enough money to do so. Therefore, although there are many clinics in Poland offering IVF technique, actually only few of them have really well-trained and experienced doctors (as far as assisted conception is concerned) and the kind of equipment that can be found in the other European IVF clinics. As a result, only those clinics, in fact, offer assistance of acceptable quality. Yet, there are many medical centers where IVF technique is performed. This makes assessing IVF practice in Poland a tricky, perhaps even dangerous activity. Moreover, as no national registry of clinics performing IVF technique exists, it is difficult to precisely estimate their total number and as such to access and gather information about their location. Thus, the 'Polish IVF' is a practice that totally lacks transparency. Furthermore, with no law concerning donation or the created embryos, every clinic is

absolutely free to operate in accordance with its own applied internal directives and regulations. In addition, clinics are not obliged to present their statistics. Yet, even if they do, the given numbers can be by no means verified for credibility. As statistics cannot be checked for veracity, information about the quality of the offered assistance is difficult to access. What is more, as every Polish clinic can set its own prices and define the types of services that have to be paid for, and as IVF technique is not reimbursed, the access to the program is severely limited (non-affordable practice). At the same time as IVF technique needs to be paid for and is mostly performed in private clinics, it becomes easy to approach its practice as something similar to cosmetic surgeries interventions applied in order to correct beauty defects. Thus it can become seen in terms of a small indisposition, complaint, whim or obsession of the rich (as also said by Prof. Fauser). Moreover, as it can be read in Raport Niepłodność (Infertility Report) (2005) that because the assistance is exclusively situated in the private clinics which per definition are profit-oriented and the costs of IVF are high, questions such as “*How much a child costs?*” can be asked and unfortunately answered (Raport Niepłodność 2005:60). Therefore, the comparison of IVF practice in Poland to commercial, money-oriented, money-conditioned and money-grounded, thus commodifying enterprise would not be surprising. As the mentioned elsewhere Bernard M. Dickens (2001) emphasizes, it is possible to argue that commercialization and commodification can be at stake when new reproductive technologies are applied. He writes “*commercialization through commodification (...) imposes a monetary tariff on all means by which children are conceived and born*” (Dickens 2001:340). In addition, as IVF technique is not extensively debated and discussed in public, for the broader part of the society it still remains an unknown, and thus strange, weird and rather alien phenomenon. Furthermore, as being condemned by the Polish Catholic Church, supporting the Vatican’s standpoint, it is seen as a method performed against God’s will. All in all, in Poland IVF technique has been turned into a practice that is not controlled, difficult to access and afford, existing in a void with limited information.

Situated Practice

The Importance for the IVF Debate

In both cases, Dutch and Polish, human in vitro fertilization stands for more than just a technology, a method. In the Netherlands with the various regulations introduced and laws passed such as the Embryowet or Wet donorgegevens kunstmatige bevruchting that comment on and regulate different aspects concerning created embryos and donation of gametes, it is rather difficult not to realize that in the process of being applied IVF undoubtedly gets the status of a practice. Yet, as it appears from the description, the idea to have certain regulations and legal framework together with the kinds of regulations, types of arrangements and the content of issued laws were all together conditioned by certain political decisions and the general cultural climate in the Netherlands. Therefore, it was due to those factors that IVF technique in the Dutch settings eventually became a transparent, relatively safe, accessible, and in general, affordable medical practice. As far as Poland is concerned, though no regulations were introduced and no general directives were issued still, by the very fact of being applied in the private medical centers, IVF technique also got the status of a practice. In Poland, in contrast to the Netherlands, the cultural factors, existing ideas concerning sexuality and fertility, religious views, the impact of the Catholic Church's doctrine, economical conditions and political climate have all influenced the way in which IVF technique has eventually come to be applied (without regulations and legal framework). The Catholic doctrine, existing ideologies and politics have caused IVF technique to become an uncontrolled, non-transparent, inaccessible and unaffordable commercial practice. All in all, I can conclude that IVF technique when it gets applied definitely becomes a practice. However, the very fact that cultural factors, ideologies, religion, economical situation and political decisions played a crucial part in forming the shape of the practice of IVF allows a conclusion that in vitro certainly represents a situated practice.

Having proved that in vitro stands for a situated practice, I would like to argue that if IVF could be seen in a different light (other than the ways in which the radical feminists and the Vatican have proposed), then, as I have said before, more positive assessment of IVF technique and IVF practice becomes possible. For both the Vatican as well as the radical feminists, new reproductive techniques such as IVF

technique qualify as abusive and oppressive. The radical feminists assess practice and technique of IVF as abusive precisely because the technique is seen as invented and operated by an oppressive man. Jana Sawicki (1991) makes it very clear that for radical feminism man qualifies as abusive as he aims at controlling not only nature, but also woman's body. Due to that, as she states, new reproductive methods and their practices are automatically perceived as man's biggest invention; the embodiment and the final step of his desire to control both nature and female bodies. Therefore, as a result new conceptive methods and their practices are immediately evaluated as having oppressive and abusive characteristics. She writes, "(...) they [the radical feminists]²¹ represent new reproductive technologies as the quintessential embodiment of a "male reality" that is violent, objectifying, controlling, dehumanizing, denaturing, flesh-loathing and misogynist" (Sawicki 1991:74). Yet, when it becomes realized that many factors participate in transforming the technique into practice and in creating the shape of IVF practice, that those practices are as Saetnan stresses, "(...) outcomes of social processes (...)" (2000:4) then it becomes obvious that those very factors are in fact responsible for what IVF technique is transformed into and how eventually, IVF practice looks. Therefore, I can argue that both IVF technique and IVF practice are not oppressive or abusive per definition. Thus, it is wrong to state that the technique and practice of IVF must always be oppressive.

This last sentence leads me to another argument that I want to make. The shape of IVF practice remains undecided until certain processes take place. When in vitro is seen as a situated practice, I want to argue, its more accurate assessment can be delivered. If it becomes realized that the shape of IVF practice is created, given and assigned in the course of certain processes, then it appears that new conceptive technologies and their practices can be assessed as always in the making, prone to arrangements but also rearrangements, and so possessing rather neutral characteristics.

At the same time, when in vitro is seen as a situated practice a more adequate and not that negative approach to it can be proposed. As I have repeated many times, for the

²¹ Emphasis added.

Vatican and the radical feminists, human in vitro fertilization qualifies as oppressive and as such they explicitly state that IVF technique should not be approved. When, however, in vitro is seen as a situated practice such an approach can only qualify as absolutely wrong if not, in fact, very dangerous. As it is cultures, ideologies and political moves that determine the shape of IVF practice, then to not approve these technologies means to possibly launch processes of not easily predictable, yet probably the negative outcomes. Thus, instead of not approving IVF, the efforts to create the best possible shape of IVF practice should be undertaken.

With in vitro seen as a situated practice there is also room for a much more positive and accurate conceptualization of IVF technique/practice. I can say that both are not abusive and oppressive per definition, but rather neutral, prone to re-arrangements, always in the making, and as such, able to take on any shape.

Situated Practice/Part of a Longer Procedure. Human In Vitro Fertilization at the Medical Centers Level

UMC/AZU and Diakonessenhuis, Utrecht, The Netherlands

Gameta and Salve-Medica, Lodz, Poland

Fertility problems are taken care of in two Utrecht's hospitals UMC/AZU and Diakonessenhuis. In both those medical centers couples with difficulties in conceiving are examined and offered technological assistance. However, in addition to heterosexual, lesbian couples can also be accepted. Single women are not usually recognized as eligible. This, as Prof. Fauser emphasizes, is not a result of any law, as the general law forbidding the acceptance of a single women does not exist, but of a consensus reached among fertility doctors. As he stated, this decision has mainly to do with the interest of a child. Next to the assistance, couples may also participate in the scientific research, the main objective of which is to make the future fertility therapy more sufficient. However, it is up to patients themselves to decide whether they want their data to be used or not. If they express no objections, they have to confirm their decision with a written agreement. In Lodz, there are two known clinics where patients may undergo in vitro. Yet, as Dr. Radwan and Dr. X.Y. say, only heterosexual couples are accepted. Single women are not considered eligible for the same reasons as in the Netherlands, meaning the interest of a child. Because of the

Polish mentality, to a high degree influenced by the Roman Catholic teaching, lesbian or gay couples are not tolerated and their relations are condemned as 'unnatural'. Therefore, as I was informed, no doctor will risk the reputation of the clinic and her/his own status by allowing lesbian couples to use the offered services. Having said this, it appears that in the Netherlands practice of IVF can be assessed as accessible to a broader group of the population meaning both hetero and lesbian couples, and applied for reasons other than fertility problems. However, in both countries (in the Netherlands at least in Utrecht) single women cannot profit from the possibilities enabled by reproductive technologies, thus it is possible to conclude that the interest of prospective children is put above those of women's.

In UMC/AZU there are gynecologists, fertility doctors, residents, co-assisting medical students, lab analysts, embryologists, and fertility nurses. Gynecologists have fixed appointment hours yet at least one of them is always present at the clinic. Therefore, if couples need to discuss pending issues is the possibility to do so. The fertility doctors' main task is to prepare and accompany IVF-ICSI patients. In addition, they are also responsible for performing the procedure itself. Gynecological residents participate in supervising the examinations and 'treatment' in close cooperation with gynecologists themselves. As they are in a training period, they usually move from one department to another. Yet, patients do not have to repeat their medical history every time they come in contact with a new doctor or resident. The point is that doctors or residents always make themselves familiar with all information concerning individual patients before a scheduled appointment. Co-assisting medical students (students trained to become doctors) are mainly auditors. However, during the patient's first visit, the medical students usually gather the first general information to be later presented and discussed with qualified doctors. Yet, it is up to patients to agree or not on the medical student's participation. Nurses assist doctors during their appointment hours. In addition, they can also be contacted by telephone to answer questions. If a nurse is not able to deal with a presented problem, she always informs patients whom they may turn to instead. In Diakonessenhuis, there are gynecologists and residents, who deal with fertility problems. Such division of tasks, especially between gynecologists and so-called fertility doctors has to do, as Prof. Fauser explains, with the changes in the organization of the doctors' work.

“The days that doctor works 7 days per week, 5 hours per day are over, so you always work in teams. We have separated inflections, all the bigger Dutch IVF centres have done that. As opposed to the most countries through out the world, here the gynaecologists do not perform IVF. The doctors that do IVF are referred to as fertility doctors. We [gynecologists]²² supervise them.” On the one hand, it seems proper to me to say that with such a system the optimal conditions for patients and for doctors have been created. On the other hand, it can be assumed that the division of tasks may result in a situation where patients encounter different doctors almost every time. However, in order to diminish the possible inconveniences of such a situation, certain solutions have been applied. First of all, each particular case is always discussed by a whole team and treated in an individual manner, thus every member of the medical staff is familiar with every case. Secondly, the gynecologist her/himself always remains the leading doctor. This basically means that after the first visit, which is always with gynecologist, when fertility doctors take over a gynecologist can be contacted at any moment. Prof. Fauser makes that clear when saying, *“Because we are for indications, counselling, and questions, I always inform my patients that I remain their main doctor, thus if anything needs to be discussed or decisions must be made, they can make an appointment and together we will talk those issues over.”* What is more, the fact that every case is discussed by a whole team allows different opinions to be articulated. This can result in suggesting the best manners of dealing with individual cases. Therefore, it is proper to conclude that in the Netherlands certain efforts have been undertaken in order to make the participation in in vitro the most tolerable one. As such I find it possible to say that the Dutch practice of IVF is, in fact, patient-friendly. The situation in the Lodz clinics differs significantly. As I was told, the division of tasks as introduced in the Dutch hospitals is not possible there due to limited financial resources. As a result, the IVF teams in both discussed medical centers are very small in size. Because of the shortage of personnel, it is usually gynecologists that supervise the whole procedure from the very beginning to the end. What is more, the infertility clinic is not the only workplace for many doctors. This basically means that they are difficult to reach during the time between scheduled appointments. According to the interviewed Polish doctors, it was not a problem until recently. The point is that the

²² Emphasis added.

number of couples has started to increase and the number of working specialists has not. Nowadays, couples need to wait up to three months, if not longer, for their first visit. Moreover, when they are admitted due to the mentioned reasons, couples cannot count on the possibility of discussing their case, clarifying ambiguities or expressing worries whenever they feel the need to do so. Furthermore, because of the size of the IVF teams and the large number of couples, it is impossible for every case to be discussed and known by all medical staff members. As a result, it is difficult to assess the Polish practice of IVF as a patient-friendly one.

In UMC/AZU (Utrecht) there is also a distinction between onderzoek (examination) and behandelings (treatment) period. Depending upon which phase patients are in, if they want to discuss certain issues, they have to contact the proper department for information service. The information service for examinations can be reached from Monday till Friday during normal business hours, whereas the treatment information service can be contacted seven days a week. In addition, if during the examination or treatment period any urgent matters need to be reported and discussed, the department's personnel can be contacted twenty four hours per day, seven days a week. In Diakonessenhuis, similarly to UMC, whenever any pending issues need to be talked over during the times of examinations or treatment itself, the hospital's staff can always be contacted. As far as Lodz clinics are concerned, such arrangements have not been introduced and applied. With the shortage of personnel and increasing number of patients, it is simply impractical to introduce these organizational solutions. As the interviewed doctors emphasized, that would have been a great help for them as well as for couples, yet the financial situation, and that alone, of each clinic determines all decisions and choices. To conclude, once more, I can say that in Utrecht practice of IVF can qualify as a patient-friendly whereas as far as the Lodz clinics are concerned, it is rather difficult to draw such a conclusion.

In all the discussed medical centers before any decision is taken, detailed and in-depth conversations with prospective patients must always take place. "*We ask a lot of questions*" confirms Ms. Boomsma and all the doctors I spoke with. What is usually inquired about is female and male medical history. However, more intimate questions concerning i.e. the frequency of sexual intercourse or family history also

need to be answered. Those first enquires are later on followed up by extensive examinations that take a long time to perform. The tests that the doctors talk about are usually the following: semen analyses, blood analyses, and in certain cases USG scans (male patients), blood analyses, ultrasound scans, post-coital test (PCT), hysterosalpinography and, if needed, laparoscopy or hysteroscopy (female patients). Before IVF itself is commenced, couples must spend a relatively long time undergoing different tests and examinations. It can take from one to two months for those analyses to be done. Therefore, it becomes possible for me to conclude that when reproductive technologies are at stake, very private issues have to be addressed and discussed. What is more, because of the first interviews and extensive number of different tests, it is possible to assume that both female and male patients can find themselves under close medical monitoring and assessment. In addition, it appears that the examination period certainly qualifies as truly demanding and possibly tiring (physically, mentally and emotionally) for couples.

On the basis of the examinations performed, doctors try to estimate the chances for spontaneous ('natural') conception. In the Netherlands, if these examinations do not indicate any obstacles for a couple to conceive, the chances for pregnancy are said to be relatively high, a female patient is about thirty-four years old, and the efforts to get pregnant were undertaken for no longer than a year and a half before the tests, then couples are advised to wait another six months. If during this time, conception does not occur then the applicable method is recommended. However, if the tests' results have not allowed the doctor to anticipate spontaneous conception, a particular type of assistance is advised immediately. The doctor determines the kind of technique that will be applied as determined by the examination. In the discussed Polish clinics, a slightly different policy is applied. If the chances for spontaneous conception are high, then couples might also be asked to wait and try to get pregnant without technological assistance. Yet, as I was informed, there are cases when couples are very persistent and they do not want to lose time on trying and waiting. As in Poland IVF is offered in uncontrolled private clinics and must be paid for by the patients, it is the patients, who in fact make the final decisions. As a result, even if a couple can conceive spontaneously this option can be eliminated and the chosen technique may immediately be commenced. From what has just been said, certain

conclusions can be drawn. First of all, it seems possible for IVF to be seen as a practice where doctors make many important decisions. Secondly, IVF practice can be perceived as abusive sometimes, mostly because certain procedures can be performed when not needed.

The types of medical assistance offered by UMC/AZU are the following: hormoonbehandeling (hormonal treatment), microchirurgie (microsurgeries), kunstmatige inseminatie met zaad van de partner (intrauterine artificial insemination with the partner's sperm, IUI), kunstmatige inseminatie met zaad van een donor (KID) (artificial insemination by Donor, AID), IVF (in vitro fertilization), IVF-ICSI (intracytoplasmic sperm injection); eiceldonatie (egg cells donation.) and ICSI-MESA (intracytoplasmic sperm injection in combination with microsurgical epididymal sperm aspiration). In Diakonessenhuis almost the same types of technological assistance can be done but with some exceptions. In this hospital only a part of IVF can take place. This has to do with the general organization of in vitro in the Netherlands. As it has been said before, when the general organization of IVF was addressed, human in vitro fertilization can only be performed in the special IVF laboratories situated in the designated hospitals. Yet, as Prof. Fauser says, many Dutch medical centers may offer certain types of assistance from the domain of new reproductive technologies such as IUI or AID. Equally, they can also carry through the first phase of IVF meaning a hormonal stimulation or collection of egg cells. However, the very fertilization in vitro (connection of female and male gametes in vitro) can only take place in those mentioned laboratories in the particular hospitals. The number of hospitals hosting IVF laboratories is precisely defined. The IVF laboratories are located in the university hospitals, which on the other hand work together with some others in the area. In the IVF daily life practice, this kind of cooperation takes place very often, in the case of Utrecht between UMC/AZU (the university hospital) and Diakonessenhuis. Such a solution can result in situations where the patients who start in vitro in one hospital must continue in another one. As Ms. Boomsma from the IVF team in Diakonessenhuis says, after the retrieval of egg cells, every couple has to transport them individually to UMC/AZU as only there can the collected material be further worked upon so that the following phases of IVF can take place. Almost the same types of assistance from the domain of reproductive

medicine are offered in Lodz clinics. As it has been said elsewhere, in Poland no regulations concerning IVF technique have been introduced. Therefore, any medical center can have an IVF laboratory and offer assistance depending on the equipment and financial possibilities. As no one controls the clinics, assistance recognized in some countries as relatively dangerous (such as Testicular Sperm Extraction, TESE, applied in the cases of male infertility) can be (and is) offered by some Polish clinics.

In order to be able to start certain forms of technological assistance, some prerequisites must be met. In UMC/AZU and Diakonessenhuis only women no older than forty-one years old can be admitted for IVF. If a woman is forty-three years old and the ultrasound shows that her ovaries are still stimulated by hormones then she can also opt for IVF. In the case of IVF-ICSI the woman's age cannot be above forty-three years. As far as IUI or AID is concerned, for a female to participate she must be younger than forty-six years old. In Lodz IVF clinics there are no strictly defined rules regarding the women's age limit. Based on the Dutch example, IVF can be assessed as a practice to which access is conditioned by certain factors such as the age limit, however, this cannot be said as far as the practice of IVF in the discussed Polish clinics is concerned.

In UMC/AZU and Diakonessenhuis when it becomes known during the first tests that the quality/quantity of spermatozoids in the examined semen is low, the IVF-ICSI method (when a single spermatozoid gets inserted into one egg cell) may be a solution. This type of technological assistance is mostly recommended in the cases of male infertility when the Classic IVF (when egg cells and spermatozoids are mixed together) cannot be an option or when previously performed IVF did not result in pregnancy. If this method is chosen, a man is asked to undergo genetic screening. This is done in order to foreclose the possibilities of the occurrence of chromosomal aberrations. Another method that can be applied when no sperm is found in ejaculation, is ICSI-MESA (when sperm is directly retrieved from a male's testis.) However, IVF-ICSI and ICSI-MESA are only advised if there are clear indications, and under special conditions defined by the hospital. If there is no sperm at all, donation may be an option. Yet the decision is always up to the couple, as Prof. Fauser and Ms. Boomsma emphasize. According to the Professor, the sperm bank is

treated as the last option by heterosexual couples as they always want to have ‘their own children’, and there are cases in which couples, if faced with a decision concerning sperm donation, choose to stop the assistance and go for an adoption. However, if donation does not constitute a problem for heterosexual couples or if lesbian couples opt for assisted reproduction, the needed sperm is obtainable. The decision of using the sperm bank or not is up to the couple, though a doctor makes the choice regarding the particular donor. In the discussed Dutch clinics in the case of heterosexual couples, the physical appearance and blood group of the prospective father determine the choice. If a couple does not have any children, it is possible to use sperm from a donor who himself has not conceived many children. In the case of lesbian couples, the prospective mother’s blood group, the number of children conceived with and the quantity of the particular donor’s sperm are taken under consideration when the choice is made. However, Ms. Boomsma emphasizes that sperm donation is mostly used by lesbian couples. Most of the treated heterosexual couples usually use their own genetic material. The overall percentage of children born in the Netherlands due to sperm donation was said to be 0,5% in 2002 (Janssesns 2003). In the Lodz clinics the situation looks slightly different. The couples that are admitted for assistance usually choose between IVF-ICSI and semen donation. ICSI is a method that is definitively more expensive than the Classic IVF but is acknowledged to be more effective. Because of the fact that IVF technique is not reimbursed in Poland, couples must spend a lot of money on visits, examinations and tests. Therefore, as the interviewed Polish doctors say, because they are already spending a fortune couples prefer spending a bit more and have a bigger chance to become pregnant. They do it “*just in case*” as one of the Polish doctor points out. I was also informed that some clinics do encourage couples to opt for ICSI. As more efficient than Classic IVF it results more often in successful fertilization, which on the other hand, increases the number of created embryos thus chances for pregnancies. The more embryos, the more pregnancies and so the more famous the clinic becomes. Due to that, in the future, more couples will possibly become its patients bringing there their money. On the other hand, however, because ICSI is very expensive many couples cannot afford it and opt for sperm donation which is cheaper. Therefore, the sperm bank is still a last chance, not because nothing else can work but because there are no financial resources available. According to what I

have just said certain remarks can be made. First of all, it appears that a man in addition to a woman can become an active participant-patient (ICSI-MESA, TESE) when new reproductive technologies are at stake. Secondly, assessment and monitoring are exercised (the need for genetic screening) and a man, as well as a woman, can also find himself under monitoring and assessment when new conceptive techniques are at stake. Thirdly, due to general arrangements (IVF technique is reimbursed in the Netherlands) the Dutch couples have more chances to have their offspring genetically linked to them. Fourthly, abuse can really happen as couples may be, and often are, advised that what maybe they do not actually need (IVF-ICSI is often recommended in Poland).

In UMC/AZU the laboratory, accredited and operating under strictly defined norms, conducts semen research, which can be appointed by the department of reproductive medicine or any other interested institution. The laboratory is also in charge of the sperm bank, where donated sperm is stored. There are precisely designated rules and norms concerning donation. First of all, the donors are not paid. The age of a possible male donor has to be between twenty and forty five and he must remain in a monogamous relationship. In order to be accepted as a donor, a male's motivation, risks of having sexual diseases, views over the idea of donation itself, and the anticipated relation towards couples and eventually born children must firstly be discussed. If the answers are evaluated as satisfactory, the male's semen is checked for its quality. In addition, the possible donor is scanned for the presence of AIDS, Hepatitis B and C, Gonorrhoe, Syphilis and Chlamydia. If the results are negative after three times testing, the sperm can be donated. The donor must also undergo genetic screening. He can donate sperm one to two times per months. In between donations, blood tests are conducted. In the hospital's sperm bank not only the donated sperm is kept. Males planning to undergo medical surgeries or therapies that may influence the quantity and quality of their sperm, but also sterilization, may also use the sperm bank. Prior to storing, the necessary medical examinations are always required. If a male is diagnosed with AIDS, hepatitis B or C, the bank may not allow his sperm to be stored. However, under certain circumstances and conditions, storing the sperm may eventually be possible usually at a later time. The sperm that is going to be stored can only be produced through masturbation. There are special places prepared

in the hospital where this takes place. The quality and quantity of sperm that can be frozen are specified by the hospital. Within five days, the sperm from three ejaculations can be stored in the bank. If underage, the male must be accompanied by his legal guardians. It is relatively common to use the frozen sperm later on for IVF or IUI although the doctors cannot guarantee that a pregnancy will in fact occur. In Poland, as I was informed, there are no general directives concerning donation. The sperm banks exist, yet similarly to the IVF clinics, they do not need accreditation, no norms are set and no control is exercised. From what the interviewed doctors say, donors do have to undergo extensive examinations and screenings, yet couples using stored sperm have no other option but to take it for granted that the sperm used is of the best (and checked) quality. From what I have just presented, it appears that men do get involved when new conceptive technologies are at stake. Even if they are not patients themselves, their participation still becomes very visible. What is more, because of the significantly high number of tests and examinations they need to go through, I can say that monitoring and assessment (that apparently do happen) are not solely reserved for female patients.

In Utrecht, as Ms. Boomsma emphasizes, if any of special methods such as IVF-ICSI or ICSI-MESA (applied in the cases of male infertility) is not necessary, and when a heterosexual couple is about to be assisted, it is IUI that usually gets recommended. However, as Prof. Fauser emphasizes, that was, in fact, the case only until recently. Nowadays, in certain cases IVF may be immediately advocated. Yet, as he emphasized such a decision must be thought over profoundly. The age of the female patient, the time during which couple has tried to get pregnant and the prognoses for spontaneous conception are recognized as decisive factors when the decisions are made. In the Lodz clinics, it is also IUI that is recommended to start with. Therefore, it is possible for me to say that in many cases IVF is not the method to start with, though in Lodz it is mostly up to couples to decide.

In Utrecht, the moment the kind of assistance is chosen, patients are informed about wachttijd (waiting time) and put on wachtlijst (waiting list). Although in the Lodz clinics such solutions have not been introduced couples also must wait in order to start the advised method. As the doctors say, there is no waiting time specified but

everything is arranged depending on the number of couples and the doctors' agendas. In Utrecht for the MESA procedure to begin the waiting time is about a year to a year and a half. In the case of IUI it is about three months. At a certain moment couples are informed about the possibilities of commencing the chosen method. Depending on a doctor's decision prior to the artificial insemination, the follicles in female ovaries can be hormonally stimulated or not. The results of the PCT test and quality of the evaluated semen as well as the inability of seeing the causes for previous miscarriages usually condition a doctor's final recommendation. Yet, as the Professor stresses, the hospital's policy concerning hormonal stimulation has been recently changed and the majority of women are not given any hormones but their natural hormonal cycle is used. In the Lodz clinics, ovarian stimulation is always prescribed. This is done in order to ensure a sufficient number of egg cells and so to increase chances for successful fertilization and the highest number of embryos. As everything needs to be paid for, couples prefer to have high chances from the very beginning. Therefore, once again, it can be repeated that in vitro can be seen, in a way, as abusive (a stimulation in certain cases can be not needed) but also dangerous (repeated stimulations can result in health impairments or even diseases) (Fauser et al 2005). In Utrecht, as far as AID is concerned, the waiting time is about one and a half to two years. This is mostly due to the miniscule number of donors (after the introduction of the law terminating donor's anonymity) and thus the limited amount of sperm available for fertilization. In the cases of IUI and AID, the inseminations are done every month. The Lodz clinics follow exactly the same scenario. If after four months there is no pregnancy, an ultrasound scan and blood analyses are performed. Sometimes, in order to continue hormonal stimulation can be advised prior to the following inseminations. According to the hospital's statistics around seventy percent of the female patients from both heterosexual and lesbian relationships become pregnant. The IUI method can be repeated up to six times. The chances for pregnancy are estimated at ten to fifteen percent after each single try and forty-five percent after the whole set of six tries. In the Lodz clinics, the number of IUIs is not clearly defined. Yet while looking at both cases, I can say that many times when conceptive techniques are at stake IVF itself is not needed. However, I still can easily conclude that the whole procedure must be very demanding (time, frequent visits to clinics, examinations, the assistance itself) and certainly has physical,

psychological and emotional implications and can possibly influence the social and private life of a couple.

According to Ms. Boomsma, if after six times IUI does not result in pregnancy then couples are informed about the possibilities of commencing IVF. To start IVF method the prospective participants must wait approximately three to four months. This does not apply if sperm donation is required. In the latter case, the waiting time is the same as in the case of AID. The reason is also the same, the limited amount of available sperm. If IVF-ICSI method is advised, patients must wait about eight months or one and half to two years if sperm must be donated. This long waiting time for IVF-ICSI is not only because of the donation, but also due to financial problems. The point, as Prof. Fauser emphasizes, is that in the insurance policy there is no distinction between IVF and IVF-ICSI. However, the second method is much more expensive thus whenever IVF-ICSI is performed the hospital must add (money) to every done ICSI. As a result, the number of ICSI must be limited which prolongs the waiting period. In Lodz clinics IVF also usually follows the unsuccessful IUIs. Yet, as it has been mentioned elsewhere, the waiting time is not specified and depends on the number of assisted couples and doctors' availability of time.

In all the discussed clinics, when couples eventually start IVF and if stimulation is necessary, hormones must be injected for two weeks in order to prepare the ovaries for further follicles' stimulation (in order to produce eggs.) While the hormones are being administered, the female patient has to come to the hospital at least one time per week for the blood tests and ultrasound scans of ovaries. If the results are satisfactory, the stimulation phase (if needed) may start. After one week, to find out how many follicles are growing, another ultrasound scan takes place. The ultrasound examinations are always followed by blood tests done in order to monitor the hormonal concentration in the blood. As Ms. Boomsma explains, those tests allow the doctor to monitor the follicular development, evaluate the effects of prescribed medicines, and so determine the further decisions. The eggs, as Ms. Boomsma emphasizes, can be collected when the follicles are about eighteen centimetres. If after the first week of stimulation, the follicles are evaluated as too small, injections must be continued and the next ultrasound is usually performed five days later. If the

follicles are assessed as relatively big, the hormones still need to be taken and the ultrasound monitoring takes place every day. The Lodz clinics follow a very similar procedure. The retrieval of eggs is performed with the help of ultrasonograph without anaesthesia (Utrecht) and under anaesthesia (Lodz). As the eggs' aspiration is said to be painful the Utrecht hospitals encourage partners to be present when the retrieval takes place. Although this medical procedure is referred to as the egg cells collection/aspiration/retrieval, what is in fact obtained is a fluid that should contain the egg cells needed for fertilization. If the aspiration takes place in Diakonessenhuis, the fluid must be delivered to UMC/AZU where the IVF laboratory is located. In order to maintain the right temperature, the fluid that is enclosed in circa ten tubes has to be carried by the male partner on his abdomen. *"To give him [male partner] a good share in the process"* says Ms. Boomsma. In the UMC laboratory and the laboratories of the Lodz clinics the obtained fluid is scanned for the presence of egg cells. If found, they are further prepared and in the meantime the male partner is asked to produce semen needed for fertilization. The doctors from all the discussed clinics assured me that couples are always informed that approximately only fifteen percent of the total number of egg cells will eventually turn into embryos. From what has been said, it appears that certainly IVF is a demanding treatment and it is the female patient that needs to take drugs, undergo many tests and examinations, not to mention the very process of egg cell aspiration itself. Therefore, once again, I can assume that IVF must have a significant impact on participants' physical, mental and emotional well-being but also their private and social life. Furthermore, it appears that extensive monitoring and assessments do take place throughout the whole procedure. At the same time, it becomes possible for me to realize that centers offering IVF try to make the whole process as bearable as possible (encouraging men to assist their partners) but also transparent (the estimations of chances).

According to doctors, the embryo transfer is not a painful process and as such no anaesthesia is necessary. Before being transferred into the uterus, the obtained embryos stay in the lab for about three to four days, and their quality is checked daily. According to Prof. Fauser, in the Netherlands there is no law regulating the number of transferred embryos. Yet, there is a consensus among Dutch doctors regarding reproductive medicine that no more than two embryos can be placed back

and recently there are more and more cases when only one embryo is transferred. This is mostly done in order to avoid multiple pregnancies. However, exceptions are possible. Female patients older than thirty-eight years can have three embryos transferred. If a couple has not previously specified the number of embryos to be obtained, it can happen that there are more embryos than can be eventually transferred. Those embryos can be frozen (cryopreserved) and stored for future transfers. Yet, the decision is always up to the interested couple. In any case, every couple must fill in a special form precisely stating their decision concerning freezing or donation of embryos for research. From what the Professor says, it is clear that couples do not have to pay for the storage of embryos. The maximum time of storing in UMC/AZU is up to six years. At the end of the second year, every couple gets a letter, in which they are asked to make a decision about their embryos stored in the bank. According to the guidelines of Dutch Ethics Committee, the embryos cannot be given for adoption to the other couples. If the couple does not specify what should be done with cryopreserved embryos, after six years they will get destroyed. In Poland, as doctor Radwan points out, every clinic decides how many embryos can be transferred. Usually two embryos are put back and if a woman is more than thirty-five years old, three. However, it can also happen that three embryos are transferred back even if the female patient is younger than thirty-five. This is mostly due to the fact that every IVF try is very expensive. Therefore, in order to increase chances for pregnancy, couples usually opt for more embryos to be placed back. Such a situation often results in multiple pregnancies. In this sense, I find it proper to say that the practice of IVF in the discussed Lodz clinics may be assessed to a certain degree as a dangerous one. This is because the multiple pregnancies pose real risks to the woman's as well as to the prospective children's health (Lambert 2002). In addition, Polish couples also want as many embryos possible to be created and then frozen for later use. The reason for this is that the transfer of cryopreserved (frozen) embryos is much cheaper than the full cycle of IVF (stimulation, aspiration, fertilization, transfer). Therefore, the more embryos that are frozen the better. In addition, as there is no law concerning embryos; clinics have their own directives and as such the adoption of embryos does take place in the Polish 'version' of IVF. In one of the discussed Lodz clinics (I was asked not to indicate the exact name of the clinic), the storage of embryos still remains unregulated; in the other, couples are asked to give a

permission for their embryos to be frozen. In the latter one, couples have to pay for three years of their embryos' storage. If after this time they refuse to pay, the embryos become the clinic's property. There is also a possibility of giving the embryos right away for adoption. Furthermore, in the discussed Lodz medical centers, every created embryo is photographed. This is done, as doctors emphasize, for the clinic's internal quality control. If, as I was informed, one day accreditation is needed, they will be able to prove (with those pictures taken) the high standard and good quality of the assistance offered. What is more, in one of the Lodz clinics, before the transfer takes place every assisted couple is shown their embryos on a monitor and later they are given a photograph of them. First of all, knowing this makes it possible for me to say that the elements of monitoring and assessment are present after the fertilization in vitro occurred. Secondly, it seems to me that trying to limit possible dangers is possible (transfer of one embryo in the Utrecht hospitals). Thirdly, it also appears that the practice of IVF can expose female patients to particular health risks (multiple pregnancies).

According to Prof. Fauser and Ms. Boomsma, in Utrecht patients are always informed that when applied, IVF may expose them to certain dangers. This type of information can also be found on the UMC/AZU web pages, as well as in the Diakonessenhuis' booklet. The same happens as far as Lodz's clinics are concerned (such information is given by doctors, or as in the case of Gameta (Gamete), is also listed on the clinic's web page). During the aspiration of egg cells, internal bleeding or infections can occur. The hormonal stimulation may not be sufficient and need to be repeated which can result in ovarian hyperstimulation. The prescribed hormones may also cause certain side effects such as migraines, increased perspiration, or abdominal pain. Apart from this, information concerning other risks linked to the IVF method, such as multiple pregnancies, is equally made overt. In addition, it is also made apparent that IVF is, in fact, of unpredictable characteristics and not always successful as sometimes the hormonal stimulation must be intermitted, the egg cells cannot be found, or the pregnancy cannot be established. The interviewed doctors also emphasized that at the very beginning of the treatment couples are told that the chances for pregnancy after the application of IVF method are about twenty-four percent. The low quality of semen, the age of the female patient and the number

of transferred embryos are usually recognized as the important factors conditioning the success or failure of IVF. Yet, as all the interviewed doctors say, many times it is simply impossible to say why firstly, a couple cannot conceive spontaneously, secondly why an advised and applied the method does not work. This is also the reason that in the Dutch clinics photos of embryos are not taken, and more importantly, are not shown to those who are assisted. As Prof. Fauser emphasizes, the fact that an embryo looks 'great' does not mean that the pregnancy will be established. For the Professor, to show embryos is to *"create an illusion"* and *"it is disrespectful to the patients because when you transferred embryos and it does not result in the pregnancy then people are very sad and they may say "how it is possible because the embryos looked so good" and then you see that to show and to say that embryos 'look good' is a creation of expectations but we [doctors] know 'what on earth' does the good looking embryo mean anyway."* To summarize, on the one hand, I find it proper to state that human in vitro fertilization certainly does not qualify as an easy procedure, but on the contrary is very demanding and even dangerous. However, on the other hand, it seems to me that the patients are always made aware of what the assistance is all about, how unpredictable it may be and what kind of risks it can bring. What is more, as I demonstrated with the example of the Dutch clinic's policy, the emotional well-being of patients can constitute an important objective for the medical staff.

In both Utrecht hospitals, assisted couples have the opportunity to share feelings/sensations concerning their particular fertility problem or to clarify the ambiguities linked to the advised examinations or the chosen technological assistance during the meetings with the fertility nurses. Furthermore, hospitals offer also the help of a social worker who can make it easier for couples to deal with the negative impacts of the applied method on their private and social life. Therefore, if necessary an appointment with a social worker can be arranged. In addition, patients commencing IVF or IVF-ICSI can attend organized information evenings four times per year during which they can discuss their concerns, but also gather all the necessary information from a doctor, an embryologist and a qualified nurse. Furthermore, if more information on fertility problems and different manners of assistance is desired, hospitals recommend patients to contact organizations such as

FREYA, Patientenvereniging voor Vruchtbaarheidsproblematiek (Patients Association for Fertility Issues), Nederlandse Vereniging van Obstetrie en Gynaecologie, onderdeel Fertiliteit, (The Dutch Obstetric and Gynecological Association, Fertility) or Stichting ambulante Fiom (Foundation Fiom). In the Lodz clinics, such opportunities have not been created. As the doctors say, there is no money to employ persons who can deliver psychological help to assisted patients. As a result, couples have to deal with their emotions, feelings and fears linked to the applied methods on their own. Due to that, once again, it becomes possible for me to say that in the Netherlands many efforts have been undertaken to minimize the realized and confirmed burdens of the assistance. As such I can say that the practice of IVF can be assessed as a practice where the heavy 'nature' of the method itself is recognized and where much attention is paid to the mental and emotional states of participating couples. Unfortunately, I cannot say the same in reference to the Polish practice of IVF.

Both Prof. Fauser and Ms. Boomsma say that a couple can do a pregnancy test at home from two weeks after the applied technique of insemination (IUI; AID) or implementation (IVF; IVF-ICSI). If positive, after another two to three weeks couples are asked to come for an ultrasound scan in order to confirm the pregnancy. The same scenario is followed by the Polish couples. In Utrecht, if the foetus heartbeat can be detected and it is a single pregnancy, the hospital supervision is no longer necessary and no more ultrasounds are advised. This pregnancy, as Prof. Fauser and Ms. Boomsma make clear, is treated as any other pregnancy established without technological assistance. However, if female patients get pregnant due to IVF-ICSI with low quality sperm, they must undergo a prenatal examination. This is necessary as the low quality sperm can increase risks of possible complications. If multiple pregnancies occur, they are also recognized as a medical indication for couples to stay under close hospital supervision. In such cases, until the child is born, frequent ultrasound scans are advised and performed. In the Lodz clinics it does not matter if a single or multiple pregnancy has been established, and independently from the method applied (IVF, IVF-ICSI, IUI, AID) frequent ultrasound scans are performed. Yet, in many cases after pregnancy became a confirmed fact, couples 'disappear'. This, the doctors emphasize, is due to two reasons. First of all, few of

the treated couples are from Lodz or its nearby surroundings. Secondly, they do not want their pregnancies to be associated with fertility clinics and the in vitro method, which in Poland is not treated as a type of a medical therapy and remains 'covered' with silence. To conclude, it seems possible for me to state that close monitoring is definitely present as far as new conceptive techniques are concerned. Yet, the monitoring itself appears to be 'higher' in the Polish 'version' of the IVF practice than in the Dutch one.

Situated Practice/Part of a Longer Procedure

The Importance for the IVF Debate

IVF gets a status of a practice with particular internal directives and arrangements. However, those are conditioned by other factors such as the doctors' decisions and agreements, but also economical conditions, cultural and political climates. In the Netherlands, lesbians may opt for IVF technique because lesbian relationships are recognized legally. Yet single women cannot use those facilities due to the doctors' agreements. It is also because of the doctoral decisions that the precisely defined age of women works as an indicator if one can or cannot go for IVF. The female age decides if she is eligible for technological assistance and also conditions the type of the recommended technique. Polish culture and existing ideologies condemn homosexual relations and as such IVF technique is unreachable for lesbian couples. IVF practice in the Dutch settings can be assessed as patient-friendly basically because the economical conditions of both the country and the clinics allow division of tasks and more doctors' time offered to patients. Due to that, psychological help is also available. In Poland, because of economic reasons such solutions cannot be implemented, at least not in every clinic. The fact that in Poland IVF technique has not been discussed on the governmental level and as such made eligible for reimbursement is a main reason for which IVF technique can be immediately recommended, IVF-ICSI technique is usually performed, the hormonal stimulation always takes place and the highest possible amount of embryos is created and transferred. All in all, I can conclude that in vitro certainly stands for a situated practice as its shape is a result of many mutually interconnected factors that create and make its final form. It also appears that IVF stands for a part of a longer

procedure (various examinations and the other types of the medical procedures precede IVF).

Previously, when looking at in vitro at the country level, I managed to prove that when human in vitro fertilization is seen as a situated practice, more positive and accurate assessment can be reached. Now, by concentrating on in vitro when located in the medical centers I would like to argue the same. The point is that as it is precisely the factors discussed above that make the shape of IVF practice, it should not be said that it has abusive and oppressive characteristics per definition, but that it has very flexible, and at the same time, neutral characteristics and stands for a 'shapeless phenomenon'. Furthermore, to see IVF as a part of a longer procedure is to realize that IVF usually follows relatively long course of time consisting of different examinations used to map out the reasons for which 'natural' conception does not occur. It is also important to realize that other medical methods than IVF may take place, before IVF itself is recommended. Thus, with IVF seen as a part of a longer procedure, it can be concluded that it is not usually immediately suggested to the couples and as such does not qualify as always abusive and oppressive.

At the same time, when IVF is seen as a situated practice and as a part of a longer procedure, more proper and less negative approach to it can be proposed. By realizing that the doctors' decisions and agreements, economical conditions and the cultural/political climate are responsible for transforming the technique into the way it is practiced and thus creating its shape it becomes easy to conclude that disapproving IVF technique and practice is not productive, but rather it is better to strive to shape it in an optimal way.

With in vitro seen as a situated practice and as a part of a longer procedure, more positive and more accurate concepts of IVF technique and IVF practice can be suggested. It seems that with in vitro perceived in the suggested ways, both a technique and a practice can be defined as having neutral characteristics, 'ready to be made', prone to many kinds of arrangements, but also re-arrangements, not usually recommended on the spot, which shows its possibly dangerous but equally very promising and helpful 'nature'.

PART II

Suggestions and Recommendations

IVF stands for a situated practice and for a part of a longer procedure. It is culture, existing ideologies, religion, economical situation, political decisions, but also doctors' decisions that influence the transformation of the technique into the practice and are responsible for its final shape. Also it is usually never immediately recommended. Human in vitro fertilization as both a technique and a practice seems to lack oppressive and abusive characteristics. It appears to be neutral, prone to various arrangements, re-arrangements, always in the making, and as such, able to take on any shape. It also seems quite clear that not approving these technologies could possibly result in a launch of processes that are not easy to predict, and have a great chance for negative outcomes. Thus, the goal is not the disapproval of in vitro, but the pursuit of the best possible shape for its practice.

In Poland, participation in in vitro is not *sensus stricte* forbidden. Yet as not seriously addressed at the governmental level, for which the Vatican to a high degree is responsible, it functions the way it does. Because of the Vatican influence and its call for a non-approval of IVF, but also the political climate, not only has in vitro become an inaccessible, opaque and unsafe practice but also in the public eyes, it has reached a status of a strange, whim-like phenomenon and commercial enterprise (Raport Niepłodność 2005:60). Due to that, in vitro has become in certain cases an oppressive technique/practice and a possibly harmful experience for those who opt for it. This is in fact, a reality. Nowadays in Poland to gather information about clinics' locations, to verify the quality and efficiency of the offered assistance, to have certainty that that the equipment used and the doctors' qualifications are of acceptable standards is a real challenge. What is more, IVF practice in Poland can very easily qualify as a practice that exposes its possible participants to life-threatening situations, for example, if they happen to end up in badly equipped clinics with untrained doctors (which makes the technique dangerous, too). Furthermore, as new conceptive techniques are not recognized as eligible for reimbursement, they can only be accessed by a very limited group of people who have, or are able to gather, enough financial means. In addition, the necessity to pay

may cast the shadow of a commercial, thus commodifying/objectifying in nature, venture over the whole procedure (the location in private clinics can only add to that). Moreover, the fact that IVF technique is offered by the private sector can also cause it to become associated with cosmetic or other similar surgeries, and as such, become evaluated in terms of whims, triviality and obsession. Furthermore, as IVF technique is not made visible/understandable to the wider public, while it is at the same time explicitly condemned, for the large part of society it stands for rather a strange, alien, weird phenomenon that goes against God's will. The Vatican's influence, economical conditions and political decisions have caused IVF technique in Poland to function in such a way that the real problems of oppression and abuse can be actualized. In Polish clinics the assistance, or one of its possible types such as IVF-ICSI technique, can be performed when it is perhaps not really necessary. Higher numbers of embryos are transferred (for financial reasons) and hormonal stimulation almost always takes place (also for financial reasons), which can expose women as well as prospective children to health impairments or even grave risks. This, in fact, is no surprise when so to say the 'money-issues' are at stake. As Naomi Pfeffer emphasizes, *"The risks and rewards are not the same for patients and doctors, especially in the private medical sector which has embraced these new techniques with such enthusiasm. The profit motive and the patient's best interests are often incompatible"* (1987:90). In addition, genetic links often cannot be preserved as in many cases couples can only afford sperm donation. Furthermore, embryos can be used for a variety of purposes, not to mention the activity of having embryos photographed (to prove the quality of offered assistance if in the future the accreditation is needed) which can, in fact, indicate the possible objectification of embryos. With call to ban IVF, its rejection and condemnation have turned IVF technique into a relatively dangerous and, in fact, rather abusive technique/practice. In addition, due to the fact that there is no psychological help IVF can be assessed as not paying attention to the emotional and physical hardships couples probably have to go through. As doctors cannot always meet with patients to answer questions and solve their problems, it is possible to see Polish practice of IVF as neglecting patients' needs.

On the other hand, in the Netherlands IVF practice can be assessed as preserving genetic ties and protecting embryos. Furthermore, IVF technique is affordable for a relatively large group of people and its practice does not evoke associations with a commercial and commodifying 'venture'. In addition, the detailed information concerning the location of the IVF centers together with the quality and efficiency of the offered services can be easily accessed. Therefore, nowadays in vitro in the Netherlands can be assessed as a very perspicuous practice, a practice that has reached a high level of transparency as no important information is hidden from the prospective patients. In addition, in many cases doctors have made it clear to assisted couples that they simply do not know the reasons for which they cannot conceive spontaneously or why the applied type of technological assistance does not work. This problem, as Sarah Franklin writes “(...) *of making sense of reproduction in a context of evidently 'incomplete' knowledge*” is “*one of the problems encountered in the context of achieved conception, both for professionals and for patients (...)*” (1997:146). In the Dutch hospitals, patients' feelings, emotions and hardships are actually recognized and are dealt with. In the Dutch medical centers, the access to technique and practice is not solely reserved for heterosexual couples and as such it is possible for those in lesbian relationships to become pregnant. IVF technique is organized (IVF practice) in such a way as to assure the optimal conditions for the participants. With the division of tasks, the possibilities for contacting the medical staff when necessary to discuss pending issues, the availability of information and information evenings, combined with the opportunities for obtaining psychological help, it seems that in Dutch clinics patients are treated with respect and their physical, mental, emotional and social well-being are incorporated in the hospitals' objectives. At the same time, in some cases couples are advised to try to get pregnant without technological assistance or the natural hormonal cycle is used before IUI, AID or IVF itself. Furthermore, when new reproductive techniques are performed, a woman's physical well-being is treated seriously (i.e. a transfer of one embryo in order to avoid health complications linked to multiple pregnancies or an avoidance of the hormonal stimulation).

The description of what it means to go through in vitro allows suggesting the Vatican, the radical feminists, feminists and those involved in men's studies that

what really matters is the shape of IVF practice. This is because the shape works as a frame, within which the prospective patients, both female and male, will have to operate, act, function and interact with technologies. IVF stands for a situated practice whose shape is conditioned by ideologies, religion, economical situation, political, but also medical decisions. Therefore, those who may have an impact on the transformation of IVF technique into a practice and on the shape of this very practice (such as, among others, the Vatican has) should seriously estimate the consequences of their actions and decisions. It can sound a bit naïve or utopian yet this is precisely the first step to reach optimal situations. The description of the dangerous outcomes due to the Vatican's rejection of IVF and of what it means for IVF technique and practice to be abusive allows suggesting that it would be much better for the Vatican and the radical feminist to abandon such an approach. Because IVF technique can be arranged in many ways and IVF practice can be given any shape, the efforts to assure that the shape will be the least abusive for those who opt for and participate in IVF should be undertaken. Of course it is possible to say that regardless of the fact that technologies, IVF including, can be particularly arranged, they will always have some oppressive characteristics because, as Sawicki emphasizes, of "(...) *the patriarchal context in which they are embedded*" (1991:72). Yet, there are many factors involved in shaping the discussed technique. As the mentioned elsewhere Michaelle Stanworth stresses, "(...) *political struggles concerning the future of reproduction (...)*" (1987:18) do indeed take place. This, on the other hand, means that it is really possible for new conceptive techniques such as IVF to be arranged in such a way that will not allow assessing it as abusive or oppressive practice or technique. Certainly, the question of how then this shape of IVF practice should be arranged and thus come to look like, follows. One example can be that given by Dion Farquhar who points out that, "*The increase of medical insurance reimbursement (...) coupled with the increased militancy of groups of other mothers to be admitted to clientele, lead to more and more people outside the traditional heterosexual couple utilizing reproductive technologies than ever before*" (2000:211). Furthermore, the descriptions of the Dutch and Polish 'versions' of IVF allow the suggestion that what seems to really be important is to have IVF technique turned into a controlled, monitored and reimbursed practice with the conviction that patients are well cared for and that the whole procedure is patient-friendly. These

characteristics come to be as a result of regulations and the legal framework that is constructed around IVF. Yet, it is not a matter of simply having implemented laws, but it is the laws that will create the situation for example, when certain prerequisites have to be met in order to open an IVF center, when locations are known, where statistics can be verified, when psychological help is offered, when patients are seen as embodied and ‘multiple’²³, when reimbursement can be expected, when any desiring person can qualify²⁴ and when the gamete donation is supervised, then these conditions create a positively shaped in vitro situation. With the Dutch and Polish examples it appears that controlled, monitored and reimbursed practice cannot be defined as abusive and so neither can the technology. This is because controlled, monitored and financially accessible practice is at the same time transparent and overt, less dangerous and not whim-like or commercial. In this sense, prospective patients can not only avoid certain inconveniences (lack of information, antagonistic and hostile social attitude), but also possible dangers and even grave risks. The Polish example demonstrates that when IVF practice is located in a private sector, IVF technique is not made understandable to the general public but also explicitly and verbally condemned by the Vatican, then participation in IVF can become an abusive experience. The Dutch example indicates that when IVF practice is located in hospitals, it is not associated with commercial and strange procedures. With this I am not trying to say that IVF practice should be located in hospitals by law. I also do not aim at arguing that IVF technique has to be coined as a medical treatment because per definition it is not. As the mentioned elsewhere Sarah Franklin emphasizes, “(...) IVF is not a ‘treatment’ or a cure, it is merely a bypass operation, ‘bridging’ a natural deficiency. Women who are infertile are not ‘treated’ for their physical condition, they are enabled to have a child, or not, despite it” (1997:146). Interestingly enough, the doctors I spoke with, among them Dr. Radwan, find themselves in an agreement with such conclusion when saying that they do not actually cure the infertility per se but aim at overcoming it. However, what I am trying to say is that IVF technique has to be made known and understandable

²³ When participants are not treated as “*a mere complex of tissues, organs and functions*” (Donum Vitae 1987) and thus are not reduced and objectified what the Vatican foresees or not paid attention to, approached as a vessel, reproductive body and reduced to an incubator as the radical feminists argue.

²⁴ Not only heterosexual and married couples, as this reinforces the radical feminists’ worries that IVF preserves and strengthens patriarchy.

because thanks to that, certain inconveniences such as sensations of participating in something illicit, strange and ‘unnatural’ can be diminished. All in all, the discussion from Part I of this Chapter allows the suggestion that the best way to take is to try to turn IVF technique into a practice that is controlled, regulated, reimbursed and, above all, patient-friendly, but also to make the in vitro method and practice known and understandable to society. Yet, with this realization comes the necessity of supervision over the content of laws, types of general and internal directives²⁵ and as such, also over those who propose laws, set rules and make and enforce particular directives/arrangements. Because it can be as Stanworth emphasizes that even if the ‘treatment’ of infertility becomes a common practice, it can still be offered solely to “(...) married, or the cohabiting, or to stable heterosexual couples” (1987:25). IVF should not be lost to the ideology of the heterosexism, thus feminists should continually keep commenting upon the existing politics of exclusion and inclusion when it comes to assisted reproduction. As I have just emphasized, the content of the proposed laws and types of the issued directives must be turned into objects of constant scrutiny, investigations and analyses. “*We can (...) continue to make demands for equal access to health care, for better information, and for more democratic processes of developing, designing, implementing and regulating new technologies*” (Sawicki 1991:92). Keeping in mind that the field of medicine likes to play the role of the institution that regulates human bodies and introduces certain forms of “*personal surveillance and social regulations*” (Turner 1991:19), those in charge of introducing regulations and defining the manners in which new techniques will be organized cannot equally be lost from the scope of vision. “*For feminists, a central issue must be the way that with IVF the medical profession assumes increasing power to determine who shall mother and on what grounds*” (Rose 1987:171). It is also of real importance to devise “*(...) feminist strategies in struggle over who defines women’s needs and how they are satisfied*” (Sawicki 1991:84) and to realize “*(...) who has the power to shape technology (...)*” (Saetnan 2000:4) and “*Who operates them and who control their use*” (Oakley, 1987:41). Jana Sawicki

²⁵ For example, the resolutions/decisions concerning reimbursement, single women’s assistance, age limits, time estimations, how long a heterosexual couple should try to get pregnant before being admitted for the program, who should be admitted for assistance immediately, who should wait, application of hormonal stimulation, application of anaesthesia during eggs’ retrieval, the number of repeated IUI, the number of transferred embryos, age specification that conditions the number of replaced embryos, the number of ultrasound scans during established pregnancy.

and Juliette Zipper together with Selma Sevenhuijsen (1987:126) write respectively that, “*Physicians and health care practitioners must be exhorted to further efforts to ensure that women are not treated solely as bodies, but also as subjects with desires, fears, special needs and so forth*” (Sawicki 1991:92) and that “*The fact that people want to use technology is not reprehensible, nor is the fact that doctors want to develop technology to ‘treat’ people’s medical problems. We should, however, be critical about uncontrolled power of the medical-pharmaceutical complex in developing new techniques and in defining norms of acceptable reproductive behaviour*” (Zipper and Sevenhuijsen 1987:126). The problem, which “(...) *complicates theory and strategy (...)*” as Zipper and Sevenhuijsen stress “(...) *is not technology (...)* [but]²⁶ *the power relations surrounding it*” (1987:120). At the same time, it should not be worried that IVF technique can be turned into a widely-known, controlled, monitored, reimbursed and a patient-friendly practice because it can be of an enormous help for its prospective users (limited dangers, accessibility, limited fear of being in or after IVF as far as public and social attitude is concerned). And yet in such a case it should be made certain that the information about the physical risks related to technological assistance; the physical, psychological and emotional hardships that can be experienced, the difficulties in delivering the right and proper diagnosis and the absolute unpredictability of the assistance itself, is always present and affects the prospective receivers of new reproductive techniques (so the oppressiveness of IVF practice that for the radical feminists, results from the fact that participants are left without any information given and that the very threats and dangers are kept away from the patients’ knowledge, do not have to occur as well as the presentation of in vitro as a miracle-like, successful and easy to predict and conduct method/practice). Furthermore, efforts should be undertaken in order to ensure that when needed, patients can always count on the doctors’ time and psychological/social service because, as Michelle Stanworth emphasizes, “*It is not technology that creates (...) danger, but the politics of indifference to women’s wishes with regard to pregnancy and birth*” (1987:28).

Furthermore, the whole discussion from Part I of this Chapter (the proposed manner of discussing in vitro, the delivered assessment, concepts, approaches and

²⁶ Emphasis added.

descriptions based on the empirical data) allows stating that the radical feminists' theory that there is always a "(...) *tendency of medicine to regard women's bodies as dangerous and diseased and its own [male scientists' and doctors'] interventions as beneficial*" (Sawicki 1991:72) should be modified. The theory that technology is constantly treated as a superior to the body and the body is per definition approached as dysfunctional is not all together proper.

Conclusion

To see human in vitro fertilization as a situated practice and as a part of a longer procedure is to propose more accurate and positive evaluation, concepts and approaches to IVF technique and practice. At the same time, the recommended manner of discussing in vitro, the proposed assessment, concepts and approaches together with the descriptions based on the empirical data gathered in the Netherlands and Poland result, in this Chapter, in particular recommendations. As presented, it is crucial for the radical feminists and the Vatican to stop calling for a ban on the reproductive technologies. Efforts should be undertaken to assure that the assigned shape of IVF practice will be non-abusive for its users. Thus, it would be good to try to turn the technique into a monitored, controlled, reimbursed and a patient-friendly practice as then the relatively optimal conditions can in fact be created. However, it should be remembered that it is important to closely supervise and examine the content of the passed laws or types of the introduced directives and the internal arrangements together with those who are in charge of their formulation and implementation. The proposed manner, assessment, concepts, approaches and description also have an outcome in certain suggestions regarding feminist theory. It seems that the theory that technology, especially in the field of medicine, is always approached and referred to as superior to the body, demands some important modification.

CHAPTER FOUR

The 'Embodied Subject in Becoming' and IVF as a Part of a Longer Procedure Where a Man is Present

In Introduction I have indicated that this dissertation will grow from empirical-textual to empirical-theoretical. This is the Chapter where this shift occurs and as such Chapter Four stands for the empirical-theoretical part of this dissertation. In this Chapter in Part I, I will present and apply almost directly Braidotti's, Colebrook's and Grosz's theories as well as Deleuze's philosophy to my empirical research with IVF couples. These theories concern the human subject that is conceptualized as embodied and embedded, undergoing constant changes and metamorphoses and it is desire fueled. To make these theories as transparent and understandable as possible I will refer to and explain other concepts proposed by these scholars such as "socius", desire, "desiring-production", "desiring-machine", "becoming" and power. Furthermore, by referring to the empirical material, I will indicate that IVF is a part of a longer procedure and that a man is present in the 'IVF matrix'. In this Part I will argue that only when the vision of the human subject is changed and only when IVF is seen in the suggested manners can it (IVF) be evaluated more positively and accurately. In addition, in Part I, I will indicate and describe the negative impact the Vatican's policy has had on IVF arrangements in Poland, the way in vitro functions in the Netherlands and the situation of the couples who face reproductive difficulties. In Part II, I will present that the proposed theories and manners of discussing in vitro, the more accurate and balanced evaluation of, concepts of and approaches to IVF, but also the descriptions result in important suggestions regarding theory of desire, feminist and men's studies theories and have their outcome in certain recommendations for the Vatican, the radical feminists, gender and men's studies concerning how to 'go about' IVF technique and practice. I will also try to indicate the possibly positive outcomes of the proposed recommendations and suggested theories for all who are 'reproductively challenged'.

PART I

The ‘Embodied Subject in Becoming’/IVF as a Part of a Longer Procedure Where a Man is Present

To suggest more positive and accurate assessment, and concepts of and approaches to IVF technique and practice, the human subject should be seen as the ‘embodied subject in becoming’ and in vitro should be perceived as a part of a longer procedure where a man is present.

I have coined the term ‘embodied subject in becoming’ on the basis of Rosi Braidotti’s (2002) discussions concerning issues of identity, subjectivity and difference. Though Braidotti concentrates on issues of female identity, subjectivity and difference, I would like to apply her understanding of the subject and subjectivity also to male subjects. With the term ‘embodied subject in becoming’ I refer to the human subject, whom Braidotti describes as follows, “*The embodiedness of the subject is a form of bodily materiality, not only of the natural, biological kind. The body is the complex interplay of highly constructed social and symbolic forces: it is not an essence, let alone a biological substance, but a play of forces within a complex web of social and symbolic relations. The subject is a process, made of constant shifts and negotiations between different levels of power and desire, that is to say wilful choice and unconscious drives. Whatever semblance of unity there may be is embodied and performed as a choreography of many levels into one socially operational self. It implies that what sustains the entire process of becoming-subject is the will-to-know. Desire is a founding, primary, vital, necessary and therefore constitutive drive to that becoming-subject. (...) Fantasies, desires, and the pursuit of pleasure play as important and constructive role in subjectivity as rational judgement (...)*” (2002:160). This is a fine and pertinent description of the term ‘embodied subject in becoming’. In Chapter Three I have already argued that in vitro is a part of a longer procedure. In this Chapter I will proceed with this statement adding that in vitro is also a technique and a practice where a man is definitively present.

Socius, Bodies and Embodied Subjectivities

“The embodiedness of the subject is a form of bodily materiality, not only of the natural, biological kind. The body is the complex interplay of highly constructed social and symbolic forces: it is not an essence, let alone a biological substance, but a play of forces within a complex web of social and symbolic relations. (...) Whatever semblance of unity there may be is embodied and performed as a choreography of many levels into one socially operational self” (Braidotti 2002:160). The “social and symbolic forces”, as I approach them, belong to, form and emerge from “socius”. “Socius” is a term coined by two French philosophers Gilles Deleuze and Felix Guattari (1983) and as Kenneth Surin explains, it signifies the embodiment of transcendental principles that “(...) subtend the constitution of the social order”, when the ‘social’ can exist only if it is characterised by the logic of necessity and continuity (2005:255,256). In order for the ‘social’ to function and simply to be, desires must be taken under control and properly channelled, or as Deleuze and Guattari say it, coded “(...) so that subjects can be prepared for their social roles and functions”. In this sense socius constitutes the “(...) terrain of this coding (...)” At the same time, as Surin stresses, socius is a machine and in order to work it needs fuel; that is desire (2005:256). However as socius works for the purpose of maintaining the ‘social’, desire must be shaped in such way as to fit (not destroy) the machine itself. The subject inevitably belongs to the socius, it is attached to it. Social forces and relations, but also as Braidotti (2002:171) points out “discursive practices, imaginary identifications or ideological beliefs”, that form and emerge from socius do not remain separated from bodies that are always sexed and situated in space and time. Bodies constitute a kind of surface where, as Braidotti puts it, “practices, identifications, beliefs” form a type of a “tattoo” (2002:171). In this sense, the body becomes the very reflection of these “practices, identifications, beliefs”, “(...) a field of inscription of sociosymbolic codes (...), and a “(...) field of forces, screen of imaginary projections (...)” (Braidotti 2002:160). The body, as she states, “is then an interface, a threshold, a field of intersecting material and symbolic forces; it is a surface where multiple codes (race; sex; class; age, ect.) are inscribed; it is a cultural construction that capitalizes on energies of a heterogeneous, discontinuous and unconscious nature” (Braidotti 2002:169). These ‘tattooed bodies’ are then “the complex interplay of highly constructed social and symbolic forces (...) a play of forces within a complex web of social and symbolic relations”

(Braidotti 2002: 160). The subject of the 'tattooed body' is a "*complex and multilayered*" embodied and enfolded one (Braidotti 2002:170). It is the subject whose, as Grosz contends, "*subjectivity (...) relations with others (the domain of ethics), and its place in a socio-natural world (the domain of politics), may be better understood in corporeal rather than conscious terms*" (1995:84). The embodied subject is a subject whose body and mind do not dance separately. There is no division between mind and body as the body itself stands for the basis and foundation of subjectivity which means that the subject is grounded in its flesh, in its bodily materiality. The type of embodiment is then conditioned by the type of the body materiality one happens to have. Elizabeth Grosz makes this very clear when stressing that the single sex assigned to the human body "*(...) makes a great deal of difference to the kind of social subject, and (...) the mode of corporeality assigned to the subject*" (1995:84). Certainly then it makes a difference in which socio-historical and spatio-temporal settings one's body is embedded. As the subject is an embodied one, forces, beliefs, identifications "*tattooed on bodies*" simultaneously become "*constitutive of embodied subjectivities*" (Braidotti 2002:160) (in this sense Braidotti (2002) writes about subjects' ("*embodied semblance of unity*") and so human subjectivity itself can be referred to as "*(...) a socially mediated process*" (Braidotti 2002:7). Saying that the body is a "play of forces" and that on its surface "imaginary identifications" and "ideological beliefs" are reflected, but also that subjectivity is embodied and that embodiment is conditioned by the corporality/materiality one happens to have, I can say that the human subject does not stay indifferent, to repeat it once more, to social forces, social relations, beliefs, identifications and discursive practices. The embodied human subject does not exist beyond those forces, practices or beliefs but finds itself in constant interactions and negotiations with them.

The Interactions. Motherhood, Fatherhood and Parenthood

As I have mentioned, forces/beliefs/discourses form, belong to and emerge from a kind of terrain where desires are coded or recoded, called by Deleuze and Guattari (1983) *socius*. The *socius* itself, Deleuze and Guattari (1983) suggest, has changed as with the introduction of the capitalist mode of production the general logic behind the 'social' got transformed. For the capitalist machine to work the capital (money) is what matters thus desires could finally become decoded and liberated from its former

codes and inscriptions. As Holland puts it capitalism “(...) *frees desiring-production from capture and repression by codes and representations (...)*” (2005:66). However, Deleuze and Guattari explicitly stress that in order not to reach its limits and becomes a state of dissolution, capitalism “(...) *is constantly opposing with all its exasperated strength the movement that drives it toward this limit*” (1983:140). The counteraction of capitalism, for the sake of its survival, is based on the re-inscription of desires. The counteraction also stands for all the attempts undertaken in order to “(...) *recode, rechannel persons who have been defined in terms of abstract quantities.*” Capitalism, as Holland explains, “(...) *recaptures and represses desiring-production in mostly temporary codes and representations, but also in the more enduring forms of (...) the Oedipus complex and the nuclear family*” (2005:66). As a result, as Deleuze and Guattari emphasize, “*everything returns: States, nations, families*” (1983:34). In this sense socius remains the terrain of codes and inscriptions. More importantly, however, the forming/belonging/emerging from it social forces, relations, practices and beliefs have one major aim: to ensure the optimal functioning of the capitalist machine. For the optimal functioning of the capitalist machine, the maintenance of states, nations and nuclear families is crucial. Therefore, social forces and relations, as well as discursive practices, etc. must work in such a way as to make the return of states, nations and nuclear families possible. At the same time bodies must be disciplined and regulated in a way that will enable, to repeat it again, the return of states, nations and nuclear families.

Forces

When having discussions with the Polish couples who have opted for IVF technique, they frequently emphasize that there is a real pressure in society on couples, female and male bodies, to create a family, meaning to have children. Remarks coming from the side of family members or friends about prospective offspring, or the fact that those friends have already had children, are treated as indicators of what the heterosexual couples should do. Many feminist publications point out that the female body stands for the most common target of social expectation concerning her reproductive capabilities/responsibilities. It is as Hardy and Makuch referring to Rich, A. (1997) write, “(...) *a major fact in women’s lives is their status as childbearers. Any further identity has been negated by terms such as “barren” and*

“childless” (...)” (2001:273). In the same vein Lesley Doyal says that, *“Most women have been brought up to expect that motherhood will be the single most fulfilling aspect of their lives (...)*” (1987:184). Married women who, as Zipper and Sevenhuijsen emphasize, *“explicitly state that they have no wish to reproduce themselves are condemned for not being ‘real women’”* (1987:131). This is because of the dominant ideology of motherhood that, as they point out, *“(…) dictates that every woman should be a mother”* (1987:133). Zucker, while referring to various authors, stresses that, *“The expectation that a woman’s most important and defining role is that of mother has been called the myth of motherhood (Hare-Mustin & Broderick 1979), the cult of true motherhood (Collins 1987; Rhodes 1988; Sandelowski 1990), and the motherhood mandate (Russo 1976)”* (Zucker 1999:768). Hardy and Makuch also point out that, *“(…) Society continues to require women to be mothers and to “give” children to their husbands, grandchildren to the couples’ parents and continuity to a family”* (2001:273). Yet, only women in stable, heterosexual relationships are seen as suitable to play mother roles. As Michelle Stanworth points out, *“(…) a belief in maternal instinct coexists with obstacles to autonomous motherhood - obstacles, that is, to motherhood for women who are not in a stable relationship to a man. According to ideologies of motherhood, all women want children but; but single women, lesbian women (and disabled women) are often expected to forgo mothering ‘in the interest of the child’* (1987:15). In a very similar vein Zipper and Sevenhuijsen stress that, *“single women are not supposed to want children”* (1987:131). In Poland, according to the Polish couples, the moment a woman and a man start living together they both are expected to turn into respectively maternal and paternal entities. The situation appears to be more acute when they are married. It almost seems as if the notion of a marriage carries with an immediate notion of parenthood. Naomi Pfeffer writes that, *“(…) having a child is treated as a natural outcome of marriage and normative heterosexual relationships”* (1987:82). In Poland marriage is still seen as the legal confirmation of the existing bond between a woman and a man and important step in both their lives. The phenomenon of marriage is also associated with certain obligations and evokes particular expectations. Mostly, marriage is interpreted as the basic foundation of a family. ‘Basic’ because to be culturally eligible to qualify as a family, the presence of children is an absolute necessity. Zipper and Sevenhuijsen refer to that when they

say that the presence of children is believed to 'save' marriage and that, "(...) *the quality of the marital relationship is judged by its potentiality to be fertile*" (1987:131). However, during the last years many Polish couples have been living together without marrying. Therefore, although children are expected mostly from married couples, recently also women and men who may not be married but living together are approached and treated as soon to become mothers and fathers. From this I can argue that there is a general ideological belief that a woman and a man, female and male bodies, especially when they share the same living space or become legally bonded cannot easily pass unnoticed if they remain childless. According to Zucker, and quoted by her Miall (1986), "*The mandatory nature of parenthood has been extended to include the role of males as well (...) all married couples should reproduce and (...) all married couples should want to reproduce*" (Zucker 1999:768). In a similar vein Greer stresses that, "*The criterion for adulthood has always been the ability to bear children, and authority has always been connected with having born them or acting as a parent*" (1985:49). One of the interviewed women confirms this situation when saying,

"We were married for five years. We were both twenty-seven years old and everybody was waiting for the first child in the family." [Mon]

One of the men also stresses that,

"There is a social pressure on young, married couples to get pregnant." [Mich]

Another interviewed woman points out to this saying that,

"In Poland there is a conviction that when people are married there must be also children. This conviction always becomes a pressure: Everyone asks when you are going to have children. In Poland it is not normal while being married to say that you are not going to have a child. In Poland you need to follow established schemes as they ensure safety. There are receipts circulating of what you should do in your life: marriage, job, and children. If you follow those prescriptions you are 'normal'

everything that is different is not. If you go beyond the scheme you get punished.”
[Magg]

The other couple in a very similar vein says that,

“The reason people get married is to have a family, meaning children.” [Justy and Ande]

In the Netherlands, the Dutch couples say that, marriage itself is not recognized as an indicator for pregnancy. There many couples live together without signing legal arrangements or they live in configurations other than marriage. However pressure to have children on heterosexual couples of a certain age who live together is similar to the one in Poland. The ‘push’ to enter the phase of parenthood also comes from the side of relatives and friends and the message is clear: *“it is time for an offspring.”* It does not always take on the form of explicit remarks and comments and yet it is very ‘tangible’. Furthermore, for both the Polish and Dutch couples the fact that their friends have children is regarded as the path they should follow. Living together and/or being married, female and male bodies evoke particular expectations. The contemporary obligations of a woman and a man, female and male bodies seem to be very well defined. Indisputably, one of those obligations, as shown, has to do with the phenomenon of reproduction and having children. Hardy and Makuch (2001) make this fact very apparent. They argue, *“Having children is a fundamental part of the life project of men and women and is seen as a necessary step to reach maturity and personal development, and to respond to what is their socially expected role, leading to the preservation of the human species”*; *“Having children, becoming parents and establishing a family (...) is considered part of adulthood for women and men”* (Hardy and Makuch 2001:272,273). The Dutch couples, similarly to the Polish ones, appear to confirm such a *status quo*.

“After living together for a rather long time we got a lot of questions as why we do not have children. When I was turning thirty, everybody was saying ‘now you are going to have children.’” [Mia]

“People were making comments about us not having children.” [El]

“People asked us about children.” [Bian]

“It is the situation around you. Friends are having children and you are the only couple that does not have children yet.” [Mar]

Embodiment

Female and male bodies do become a “play” and “interplay” of emerging from socius social forces, relations, practices, beliefs but also of discursive practices. There is no ‘body’ that does not evoke certain expectations, that does not call for certain attention and does not create particular responses. At the same time, everything that gets ‘tattooed’ on the bodies, everything that the bodies become a reflection of, is crucial for the creation of particular subjectivities and subjects (“semblance of unity is embodied”). The societal expectations and pressures on female, but also male bodies, to enter the phase of motherhood and fatherhood together with the general beliefs that those bodies under particular conditions (i.e. when living together/being married or at certain age) should become the maternal and the paternal bodies have resulted in very particular situations. The Polish and the Dutch women I talked to actually started feeling that being the female bodies marked by a certain age and remaining in relationships with their male partners, they should pass into a different phase and became identified with the maternal entities/realities. This goes well with Stanworth’s (1987) comment. She writes, “(...) *ideology of motherhood attempts to press women in the direction of child-bearing, and that in this sense women’s motivations are socially shaped*” (Stanworth 1987:16). However, men also began to realize that fatherhood is what they should experience. The general societal reminders regarding what female and male bodies are for had a real impact on the couples. They eventually accepted that the status of mother and father was crucial for them to reach. The couples began to agree that it was of real importance to enter and explore the dimensions of parenthood. Naomi Pfeffer emphasizes that, “*The decision to embark on parenthood, to undertake a major change in social status, antedates the attempt to conceive (...) [and] is the result of processes that are shaped by social and historical forces (...)*” (1987:83). Therefore, I can say that the certain social and symbolic forces and relations together with discursive practices and ideological beliefs had a significant share in creating the situation in which the couples started to consider parenthood as a desired state.

“At that moment we did not really feel like having a child but there is this conviction that married couples have to have a child. We did not really want to but we knew we had to become pregnant as what the family would think about us. I was not very convinced or determined, but we wanted to have a child because of the family.”
[Magg]

“We have lots of friends our age and quite frequently you hear that someone has a child and so maybe it was the pressure that we also started to feel like having a child of our own” [Lid]

“Situations change. Relations with friends change because they have children. The situation makes it more difficult to accept the fact of not having children.” [Mar]

Hardy and Makuch also point this out saying, *“(…) the desire to of the couple to have a child is a complex one, determined by many family expectations”* (2001:273). In this sense, I can say that female and male bodies definitely stay for the “interplay/play of social and symbolic forces”, that the “semblance of unity is embodied”, that the subject per se does stand for the “play of forces within a complex web of social and symbolic relations” and the “interplay of highly constructed social and symbolic forces” where the ideological beliefs and discursive practices give shape to the subjectivities and are able to channel the subjects’ desires.

Disability, Difference, Sexuality and Infertility

I have mentioned when referring to Deleuze and Guattari that the capitalist machine decodes human desires in order to eventually recode them again. It *“(…) frees desiring-production from capture and repression by codes and representations, while at the same time it recaptures and represses desiring-production in mostly temporary codes and representations, but also in the more enduring forms of (...) nuclear family”* (Holland 2005:66). According to the description above, the recapturing of desiring-production in the form of the family is accompanied by the other ‘desired’ representations, one of which I want to suggest, would be of a ‘fit’ individual. When it comes to human reproduction, a ‘fit’ individual is able to become pregnant/establish pregnancy that will end with the birth of a healthy child. The, so

to say, 'state of fitness' is clearly defined, works as a norm and has a normative function.

Forces

Once again, as previously with the ideology of parenthood, the everyday reality of the Polish couples appears to confirm this situation. The women and the men I talked with point out that society privileges 'fit' bodies and has little tolerance for deviations from the established and functioning standards of 'fitness'.

"The world likes slim, healthy, smart, and wise people. If you are not one of them, you are not welcome. Disabilities and differences are not something to be approached positively." [Mon]

"Deviations from norms are punishable. When you are different you are a 'bit worse' than others. Your 'difference', your 'otherness' maybe will not be condemned but will always attract people's attention." [Magg]

According to the Polish couples in Poland, there is a general belief that women and men, female and male bodies should not, and even more, do not have problems as far as reproduction is concerned and that something such as fertility problems simply does not exist.

"People think that there is nothing easier than getting pregnant. How can 'making' a child be a problem?" [Ter]

"We know that people like to say: So 'wise' but to 'make' a child is too much for them" [Ali]

"Everyone thinks that no one has a problem." [Bea]

Therefore if there is a conviction that no problems exist, the couples are faced with pity or disdain from others.

"If people know that you cannot have children they immediately start feeling sorry for you." [Ewsi]

“People are real hypocrites, they will maybe show that they understand but behind your back they will be talking about you probably saying that you must have done something really terrible in your life that you now have such problems.” [Mon]

Furthermore, reproductive ‘fitness’, as the Polish couples make clear, is usually expected from male bodies. I can say that in Poland there is a conviction that a man should fulfil his masculine duties by getting ‘his woman’ pregnant with no obstacles whatsoever. If a man turns out to be unable to ‘fulfil his obligations’, he can very easily be stigmatized as disabled, weak and not masculine enough. As such he may become an object of mean remarks and jokes. Furthermore, from what the Polish couples, especially females told me it can be concluded that it is woman, the female body who has always been made ‘guilty’ if there were any problems with reproduction.

“There is a ‘common procedure’ to blame woman when there are no children and no one thinks that maybe it is not her who has a problem.” [Ewsi]

The situation where there is a general belief that to have a child is not a problem, that there are no fertility difficulties, where a man is always seen as reproductively fit and a woman is always made responsible for reproduction (and the following them responses: pity, disdain, jokes and judgements) is said to be conditioned and maintained by the fact that problems with reproduction have not been publicly addressed and debated.

“No one believes that there is a problem [infertility]²⁷. Thus no one publicly talks about it. And so everyone believes that there is no problem. Therefore, if someone has a problem and admits that they will not have an easy time. The truth, however, is that almost half of the couples have a problem.” [Justy]

“No one sees that couples have problems. No one talks about it and the whole issue seems non-existent.” [Viol]

“No one sees that people have fertility problems, that infertility is a reality. This happens because there is no general, public discussion.” [Mon]

²⁷ Emphasis added.

“No one talks about infertility. There is no information about it. No one knows it exists for real.” [Viol]

“Infertility is not a subject of discussion thus many people do not see it as a problem.” [Bea]

“It was a shock for us to realize that problems with conception do exist. We were really scared because it always seems to us that such problems did not exist. The reality, however, is different. It is almost epidemic. It is not that you say we want children and we have them. The problem does exist, it only seems it doesn't.” [Lid]

“Infertility is becoming a plague. We have many friends experiencing it. Both females and males have problems with fertility. Yet, on the general public level, no one seems to notice that.” [Ew]

At the same time, the interviewed couples mention that in Poland fertility problems are seen as a taboo. In Poland (see also Chapter Three) infertility has the status of a taboo, shameful and embarrassing matter. The Polish socius, I would suggest, though familiar with the capitalist production is also a very conservative one and likes to re-code desires in the spirit of the Roman Catholic ideology. Bryan Turner stresses that, *“Human societies can be conceptualized in terms of (...) institutional arrangements for the management of human embodiment; law, religion and medicine regulate and control human embodiment. Religion, through a variety of ritual practices, regulated and constrained the human body with the aim of developing our spiritual existence”* (1987:19). In the Roman Catholic doctrine the human body has to remain under certain restrictions and be disciplined. This mostly indicates the control of desires, passions and temptations, such as the sexual ones. As I presented before, in Poland a woman and a man, female and male bodies, which share the same space, live together and/or are married are expected to become respectively a mother and a father. Ellen Hardy and Maria Yolanda Makuch write that, *“Human sexual life had a simple and predictable outcome: a man and a woman lived together and had a sexual intercourse, frequently followed by pregnancy and the birth of a healthy baby”* (2001:272). Female and male sexuality, though the first to a much higher degree (Shoat 1998; Groneman 1995; Tuana 2004; Moore and Clarke 1995) are then thought about as being channelled into reproduction, into becoming a mother and a father. It is because, as Stanworth points out, sexuality, parenting and family

should always go together (1987:23). In a similar vein Zipper and Sevenhuijsen emphasize that, “*Sex, love, steady relationships and motherhood were supposed to belong together whereas passion and commercial sex were banned to the ‘dark’ and forbidden side of the border*” (1987:122). As in order to become a mother and a father sexuality must certainly come to a play, the conception of a child is inevitably linked to a sexual sphere of the human life that is intimate and private. Bernard M Dickens emphasizes that saying, “*(...) the conception and birth of children has customarily been regarded as a private or family matter, regulated by the unpredictable chance of nature or as a divine mystery outside decisive human control*” (2001:337). Everything works fine, I want to argue, when pregnancy happens without any additional efforts and when there is no necessity to discuss how ‘it happened’. However, the problem arises when conception does not occur and the very moment of how ‘it happens’ not only has to be addressed, but very closely focused upon. The problem arises because female and male bodies must then be seen as sexual and their sexuality must be put on display. Because as Zipper and Sevenhuijsen write, “*(...) motherhood served as a ‘protection-racket’ against the dangers of sexuality*” and “*(...) a motherly image of Woman could not be combined with a sexual image (...)*” (1987:122) to touch upon ‘sex’ is to admit that underneath the image of a female and a male as a mother and a father lays the one of the sexually active subjects. As sexuality is a taboo, such ‘admittance’/‘confirmation’ is not welcomed. Because the conception of a child or fertility problems demand the display of the sexual selves and the confirmation that female and male bodies are sexual, they immediately become classified as a taboo. Similarly, like with the general beliefs concerning reproduction, the fact that infertility in Poland still remains a taboo, is accordingly to the Polish couples mostly determined by the lack of the public attention and governmental open debate concerning those issues. This in turn, is to a great degree conditioned by the Catholic Church’s standpoint.

“Reproduction is linked to sexuality; sexuality is a taboo so reproduction should happen behind closed doors and windows not in the public, daily light. And so it does. And so situation does not change. Both reproduction and sexuality remain a taboo.” [Pau]

Similarly to the Polish couples, the Dutch couples also mention that societies prefer and favor 'fit' bodies and that deviations from the generally accepted norms, especially in the realm of the human reproduction, are not easily accepted. However, they usually do not mention the same 'types' of beliefs widely circulating in the Polish society. What is more, contrary to the Polish, the Dutch couples do not point out that the difficulties with conception are seen as taboo or embarrassing issues. Even though they inevitably belong to the sexual domain of the human life, they are not defined as shameful. From what the Dutch couples say, it appears that human reproduction and fertility problems are rather openly discussed and taken 'out of the closet' which allows society to become much more familiar with the phenomenon.

"In the Netherlands, no one pretends that infertility is not a problem. You are not afraid to say that you cannot have children though you certainly do not announce it to the whole world." [Mia]

"In Holland we have had many years of trying with IVF and the reactions to infertility are different." [Syla]

Embodiment

The same as in the previous section, I want to stress that the social forces, culturally constructed beliefs and norms do not remain separate from the subjects' bodies. As the subject is an embodied one, these also do not remain distant to embodied subjectivities. In Poland, fertility problems are approached as private, intimate, shameful and embarrassing matters, taboo. Furthermore, female and male bodies are thought about as needing to keep their sexualities guarded and out of the public sphere. As a result, the interviewed couples with 'reproductive problems' felt ashamed to discuss their issues that inevitably touched upon the sexual sphere of their lives and as such stayed quiet and overt.

"If you visit gynecologist or sexologists, you do not 'lean out' with it." [Magg]

"For us it was all a taboo so we did not want to talk about it." [Mal]

In the Polish society there are certain beliefs concerning bodies and human reproduction (to repeat shortly, everyone can have a child, the male body is always

reproductively 'fit' and the female body is always responsible for reproduction) and certain reactions follow when what is believed in is not confirmed (pity, disdain, jokes, mean remarks and judgements). These are reasons that couples, especially the men, felt embarrassed about their bodies if they exhibited signs of 'fertility impairments'. Feeling embarrassed and at the same time wanting to avoid being pitied, joked about or judged, they were not prone to discuss or share their experiences with the conceptive difficulties.

"You did not talk about your infertility as you are afraid of mercifulness and pity, of being seen as 'worse', 'disabled' or not 'fully valuable. I cannot imagine saying that I cannot have children. I will be not only ashamed but others will pity me. I hate that." [Magg]

"I do not want to discuss my things because people will immediately start feeling sorry for me. I do not want that." [Ewsi]

"I do not want to talk because I do not want to be seen as a 'sick' person." [Mon]

"It is so hard to admit openly that you have a problem if everyone thinks that there cannot be any." [Bea]

"I think it is especially hard for a man to talk about it. My husband, it was very difficult for him. I know he felt humiliated, not 'masculine' enough, almost 'disabled. He never mentioned anything to anyone. He works for the military.'" [Magg]

"I knew that if I had told, I could have been seen by others as 'not one hundred percent man.'" [Lid]

"Men are simply embarrassed to talk about infertility..." [Ewsi]

"I know that among my friends there are many problems, yet everyone says that everything is ok. No one wants to talk, especially men, in order to not be seen as not masculine enough." [Mon]

"People have problems but they will not talk about them." [Justy]

"People are simply ashamed to admit that they cannot have children."[Ew]

In the Netherlands problems in the sphere of reproduction are usually not perceived in the way they are in Poland. Thus, the Dutch couples did not stay secretive or silent. On the contrary, they did not feel embarrassed but talked about their problems when they wanted to. Although being infertile was not something the Dutch told

everyone, still they did not have difficulties with being open about their reproductive situation if necessary.

“I did not have problem talking about it. It just takes some time to announce it.”

[Mia]

“My family knew that I want to have children but it became a subject you really do not want to talk about.” [Ane]

Both the Polish and the Dutch couples felt ‘uneasy’ about their inability to conceive a child. In both cases it has to do with the fact that societies privilege ‘fit’ bodies and have certain norms/standards of what ‘fit’ should mean when it comes to reproduction. The fact that conception could not occur in a ‘normal’, or I would rather say ‘normative’ way and as such the ‘fitness’ of the couples’ bodies could not be confirmed, was a source of ‘uneasy’ feelings for many couples. This is not that much of surprise because as Hardy and Makuch notice, *“(…) women and men who are infertile feel socially inadequate in a predominantly fertile society”* and so (what the surveys they base their discussion on show) *“(…) both men and women who experienced infertility were more distressed than the general population”* (2001:273,275).

“You really feel bad when you have a problem and others around you don’t.” [Mag]

“Your infertility is always present. You are on the street and you see those pregnant women; women with baby-carriages. Children are everywhere. You cannot go anywhere without being exposed to children and then your body betrays you every month again. You wonder why it is you. What is wrong with you?” [Mia]

“You really feel bad as you do not understand what is going on with your body.”

[Ane]

“You see children everywhere. You are constantly exposed to children.” [Fos]

In both countries most of the time the women felt more ‘uneasy’ than the men. This is a very good illustration of what Hardy and Makuch (2001) write about. They emphasize that many studies confirm that, *“(…) women reacted more strongly to infertility than men”* and *“(…) rated themselves as experiencing greater social*

effects of infertility then men” (Hardy and Makuch 2001:273). In Poland, I would say that this mainly has to do with the circulating beliefs and convictions concerning female bodies. As far as the Netherlands is concerned, such a situation may indicate that even if the Dutch couples do not confirm that female bodies are culturally constructed as ‘reproductively responsible’, this way of thinking is prevalent in their manners of reasoning and conceptualizing experiences with fertility problems. One of the interviewed women says that her ‘uneasy’ feelings had a source in a fact that her husband already had had a child in his previous marriage.

“I really felt bad not getting pregnant especially that my husband’s ex-wife got pregnant with him.” [Pau]

Another one says that she felt really humiliated by her mother in-law who was emphasizing that there were still no children in the family.

“My mother in-law was telling people that her son does not have children and that it is probably because of me. This made me feel really bad.” [Mon]

One woman also says that not becoming pregnant she would have thought that,

“I am a failure. I am married and I cannot give my husband a child. He loves children and what if in few years he would have met a woman and got her pregnant?” [Dus]

In a similar vein another mentions that,

“You start to think that you are not really a full woman. I really think it is our community.” [Ane]

“I felt ashamed that the others have children, that maybe I am not a good woman that I cannot have children.” [Jus]

Yet, in the case of the Polish couples those ‘uneasy feelings’ simultaneously stood for an outcome of the discussed reproductive beliefs. In Poland couples felt ‘uneasy’ not only because they could not have easily proved their reproductive ‘fitness’ but

also because of the realization that to conceive a child, what had seemed so ‘natural’ and easy, turned out to be rather difficult. Still, however, from what the Polish couples say, the feelings of ‘uneasiness’ and ‘shame’ were also experienced by the men.

“It is like not being able to confirm your masculinity.” [Lid]

Given the above discussion, my statement, following Braidotti’s, that the human bodies do stand for an “interplay of social and symbolic forces”, that “semblance of unity is embodied” and that the human subject as such does stand for an “interplay of social and symbolic forces” that not only circulate in contemporary societies but are also strongly rooted in the body of socius which simultaneously forms its shape, seems to be the accurate one.

Socius, Bodies and Embodied Subjectivities

The Importance for the IVF Debate

As I have previously argued, what the subjects are surrounded with, immersed in and embedded in, never remains separate from them. On the contrary, constant, in-between interactions endlessly take place. As a result, the subject becomes the ‘outcome’, the “interplay” or the “play” of those in-between flows and connections. With this I am not trying to say that the subject lacks agency or becomes a marionette whose strings are controlled by invisible hands of defined/undefined powers. What I am trying to say is that the subjects, by the very fact of remaining in continuous relations-negotiations with the world around them, can experience certain forms of sublimation, or like Foucault would have said, “*personal surveillance*”. Subjectivity, thus the subject itself, is always an effect of many interactions and inputs. It is crucial to comprehend that the subject does stand for the “interplay of forces” as thanks to that, it becomes possible to acknowledge that those forces play a very significant role in not only shaping the subject as such, but also in the subject’s decision-making processes. With this realization it gets possible to conclude that forces, relations and beliefs do matter when it comes to choices, actions and decisions made by human subjects. As I have emphasized, the acknowledgement of this fact should not lead to a belief in the subject’s total lack of agency and power.

This acknowledgement, however, should lead to the realization of how much the established and circulating norms, ideologies and beliefs matter when it comes to the human body, the human subjectivity, the human subject and its very actions/decisions/choices. As the forces and relations differ and are of specific characteristics (i.e. carrying the messages of the desired mother-and-fatherhood, of the discredited disabilities/differences and of the shameful sexualities) they result in the specific forms and actions of the subjects. In the former part I have discussed that the couples began to consider parenthood as a desired state because of the cultural 'pushes' into the direction of motherhood and fatherhood and the 'environment' that is full of examples of what the female and the male body should be. Furthermore, I have also presented that the couples started to feel 'uneasy' about their inability to get pregnant and at the same time ashamed, embarrassed, silent and secretive (the Polish couples) because of the forces, beliefs and practices concerning bodies and reproductive sphere of the human life. Therefore, I can say that it is due to those social and symbolic forces that particular actions were undertaken, choices and decisions were made. The moment the couples agreed upon the fact that the motherhood and fatherhood was what they should experience, they undertook efforts to become pregnant.

"When the younger brother of my husband and his girlfriend got pregnant we wanted to have a child as well and we immediately started to act." [Mon]

"It could have been a pressure coming from our group of friends and family that we started to think about having a child. We were really into that idea and we began to try." [Lid]

"For us to be married is to become a family but you cannot be a family without a child. It is a child that defines a 'family' and that defines a 'parent. So we decided to go for it." [Justy]

"If you are married and you want to have a family, you have to have children. Children are the essence of a family. We wanted to have a family thus we made a choice to go after the pregnancy." [Ali]

"Being exposed to children everywhere, having all those questions about children, turning thirty we started to fight to have children of our own." [Mia]

The 'uneasy' feelings about 'conceptive inabilities' became a reason that couples began to think about getting out of the unwelcome situation by trying to confirm their bodily 'fitness'.

"Knowing that my mother in-law talks with people about me and my husband not having a child, I wanted to prove to her and to them that I will have a child, that I am a healthy person and that I can and I will have a child. I had to find a way." [Mon]

"My husband and his ex-wife, they had a child. I wanted to show that I also can have a child, that I am not worse. I had to do everything I could have had to do to have a child of our own." [Pau]

Those very forces, as defined in the former parts, also had implications for the general well-being of the couples, especially the Polish ones. Feeling ashamed, being silent and secretive they could not share their worries, express their feelings or talk important issues over and emotional disturbances followed.

"The worst was to hide it. The feeling of loneliness was difficult to bear." [Magg]

"It was impossible to share our experiences with anybody. It was really hard not to be able to share them." [Ali]

"It was not easy to be left all by ourselves." [Mal]

"We could not have admitted that we had a problem. You do not know how people are going to react. There is none you can talk with. This is awful." [Bea]

When the discussion aims at assessing and proposing the most adequate approaches to and concepts of in vitro, to recognize that the human body, subjectivity and thus the subject *per se* stand for an "interplay" of the social/symbolic forces, relations, beliefs and practices remains crucial. First of all, with this comprehension, new reproductive techniques can be assessed much more positively and accurately than they were by the radical feminists and the Vatican. With the acknowledgement that the subject stands for the "interplay", it becomes very clear that the forces do shape the human subject and have impact on its choices and actions. Given that the forces have certain characteristics such as those imposing the notions of the mother-and-fatherhood, it is possible to conclude that it is not the new conceptive techniques as

such that make people prone to opt for a child in the first place. In fact, if anything can be charged with such responsibility, it should be firstly the norms, practices and ideologies that characterize the contemporary times the subjects live in. Furthermore, I can also argue against the radical feminists' statement that IVF technique, with no exceptions, makes women want and eventually try to have a child. Following, I can equally oppose the statement that IVF as a technique always strengthens the notions of motherhood, and so patriarchy, and as such is abusive per definition. What then appears to be abusive, oppressive and harmful are the established and normalized 'standards of being' and ideologies so present and strongly rooted in cultures, societies, mentalities and politics: the wide and powerful 'body of socius'.

The same can be said in reference to the general societal attitude towards disabilities, differences and exceptions to the agreed upon and 'believed-in' standards (in the discussed context, reproductive standards). When there are deviations from the norms, then those who are marked by such difference cannot easily find the acceptance they would like. Therefore, if couples eventually end up in IVF clinics, it is a real exaggeration to say that the very existence of such medical centers allures them just by simply existing. Here, I am not saying that the in vitro method cannot be used by those who do not need it in fact. What I try to emphasize, however, is that, among other things, it is the demand to be good enough, fit enough and proper enough that actually made the couples undertake efforts to become as 'required'. It is then right to stress that those demands were crucial for the couples' decisions and following them actions (that might have eventually led them to the IVF centers) and not the existence of the IVF method itself. Therefore, I want to emphasize that to recognize that the subjects are the "play "of forces, where the forces are very hostile towards differences and deviations from norms but also carry certain convictions, is to deliver a more positive assessment of new conceptive technologies such as IVF. This recognition also makes the evaluation of human in vitro fertilization more complete thus more accurate as it enables the realization that those are the very forces/relations/practices/beliefs that have to be seen as constitutive/influential for the actions undertaken and not solely the technologies themselves.

Furthermore, to acknowledge that the human subject stands for the “interplay” of various forces, relations, beliefs and practices, where the latter ones advise parenthood to everyone, do not tolerate disabilities and differences, and prevent the private from becoming public, is to be able to propose a much more adequate approach to human in vitro fertilization than the one proposed by the radical feminists and the Vatican. With this I want to argue that not approving reproductive techniques is not a good solution or a correct path to take. The existing ideologies concerning parenthood are strongly rooted in contemporary realities, as is the presence of rather hostile attitudes towards disabilities, differences and deviations from the established norms. One feminist, Klein, who opposes technologically assisted reproduction, admits (to quote from Deborah Lynn Steinberg (2000) *“This, in the context of general social (patriarchal) pressures on women to become mothers and of the stigmatization of infertility, accounts (...) for why women choose to undergo the procedure.”*) I am rather surprised that while saying this she still advocates the total rejection of Assisted Reproductive Technologies. The radical feminists’ claims that the IVF technique can strengthen maternal ideology cannot be simply rejected and dismissed. However, I still want to contend that the social forces will not change and couples will not stop wanting children or stop trying to overcome their ‘inabilities’ just because assisted reproduction might be banned. With human subjects seen in the way proposed in this dissertation IVF technique does not appear to be abusive in the sense that it pushes couples into the embrace of the parenthood ideology. On the contrary, the suggested perception of the human subject allows defining socius as a terrain of possible abuse and oppression. To repeat again, with the IVF method banned, the norms, values and ideologies are not going to be changed. Therefore, I would suggest that instead of not-approving technologically assisted conception, efforts should be made to prevent IVF technique from being turned into a ‘help apparatus’ and the only solution proposed by the supervising and normative-like socius.

Furthermore, with the subject seen as “interplay”, the IVF method can be re-conceptualized as ‘not-always’ imposing the notions of motherhood, alluring and making people opt for a child, thus being altogether an abusive and oppressive technology.

Desires, Power, “Process” and the Human Subject

Addressing the issues of identity, subjectivity and difference Rosi Braidotti writes that, “(...) *what sustains the entire process of becoming-subject is the will-to-know*” (2002:160). She also emphasizes the power of desire in life of any human subject when writing that, “*Desire is a founding, primary, vital, necessary and therefore constitutive drive to that becoming-subject (...)*”; “*The subject is a process, made of constant shifts and negotiations between different levels of power and desire, that is to say wilful choice and unconscious drives (...)*”; “*Fantasies, desires, and the pursuit of pleasure play as important and constructive role in subjectivity as rational judgement (...)*” (Braidotti 2002:160). Those are the next characteristics of the human subject which I have grouped together under the concept of desire. They are also important ‘elements’ of what I refer to as the ‘embodied subject in becoming’.

Desire

Regarding the concept of desire, the way I want to address it is unequivocal with Gilles Deleuze and Felix Guattari’s comprehension of the term. In the philosophical tradition desire has been generally equalized with lack though Baruch Spinoza, on whose concepts Deleuze and Guattari are in fact based, is an important exception here. Deleuze and Guattari make this fact evident emphasizing that, “(...) *the traditional logic of desire is all wrong from the very outset: from the very first step that the Platonic logic of desire forces us to take, making us choose between production and acquisition. From the moment that we place desire on the side of acquisition, we make desire an idealistic (dialectical, nihilistic) conception, which causes us to look upon it as primarily a lack: a lack of object, a lack of the real object*” (1983:25). According to them, when desire is seen in such a way it indicates that “(...) *the real object that desire lacks is related to an extrinsic natural or social production, whereas desire intrinsically produces an imaginary object that functions as a double of reality, as though there were a “dreamed-of object behind every real object”, or a mental production behind all real productions*” (Deleuze and Guattari 1983:26). They both criticize understanding of desire as producing only fantasies and as producing those fantasies by “(...) *detaching itself from the object (...)*” intensifying “(...) *the lack by making it absolute: an “incurable insufficiency of being, (...)*” For them to reduce as they stress “*desiring-production to a production*

of fantasy (...)” is to define “(...) desire as a lack, rather than a process of production (...)” (Deleuze and Guattari 1983:26). Therefore, in *Anti-Oedipus* (1983), while arguing against this negative notion of desire, Deleuze and Guattari strive for a radical redefinition of the term. They point out that what desire produces is not fantasies or imaginary landscapes but the real. For them the desire produces reality and its product is equally real. They conclude that “*Desire does not lack anything; it does not lack its object. (...) Desire and its object are the same thing (...) Desire is a machine, and the object of desire is another machine connected to it. Hence the product is something removed or deducted from the process of producing: between the act of producing and the product, something becomes detached, thus giving the vagabond, nomad subject a residuum. The objective being of desire is the Real in and of itself*” (Deleuze and Guattari 1983:27). Desire does not lack the object but is equal with it and it does not enclose itself within the production of fantasies but so to speak ‘real reality.’ As desire produces and its product is real, “(...) the real is not impossible; on the contrary, within the real everything is possible, everything becomes possible” (Deleuze and Guattari 1983:27). Alison Ross stresses, “*Instead of a regulation of desire by pleasure or lack in which desire is extracted from its plane of immanence, desire [becomes seen]²⁸ as a process in which anything is permissible*” nothing can in fact “(...) break up the integral process of desire”, process being understood “(...) as the construction of assemblages” (2005:64). In this sense, the idea of desire as lack and negative force becomes redefined as productive and positive. Desire becomes understood, as Braidotti (2006) emphasizes, not as “*lacking*” anything but as being about “*plenitude*”. Re-conceptualized in such a manner, the concept of desire not only, as Ross emphasizes, “(...) is viewed (...) as an experimental, productive force, but also as a force able to form connections and enhance the power of bodies in their connection” (2005:63). In the same vein Grosz, while referring to Spinoza, Deleuze and Guattari emphasizes the importance of redefining desire as something productive that, “(...) does not provide blueprints, models, ideals, or goals. Rather it experiments; it makes: it is fundamentally aleatory, inventive” (1995:180). According to her, to abandon the equalization of desire with lack is to see it as “*pure positivity,*” “(...) the force of positive production, the action that creates things, makes alliances, and forges interactions”

²⁸ Emphasis added.

(Grosz 1995:179). Desire understood as this positive force allows the conclusion that to desire is certainly to produce, but also to be passionate and joyful. Desire defined as a productive force permits realization that to desire is to be active and intense in undertaken actions. What is also important to comprehend is the correlation between desires and needs. Deleuze and Guattari (1983) argue that desire does not have its roots in need(s). For desire to be connected with need(s) is to again disengage it from the desired object and as such, again equalize desire with lack. If to desire is to strive for the needs to be satisfied (to possess the desired object) the moment they cannot be fulfilled (the desired object cannot be reached) the subject is left with nothing. In this sense desire becomes associated with negative forces dragging the subject to the limits and eventually leaving it, let me say, in an 'empty space of disappointment'. Because of that, the desiring subject itself becomes a passive, tired, and troubled victim of unfulfilled promises. Therefore, Deleuze and Guattari (1983) argue for two important realizations to take place. First, as I have already mentioned, they emphasize that, "*There is no such thing as the social production of reality on the one hand, and a desiring-production that is mere fantasy on the other*" (Deleuze and Guattari 1983:28). Secondly, they stress that desire must be seen as linked to the very reality of desiring subjects or as they put it, to the "*conditions of objective existence*" (Deleuze and Guattari 1983:27). Those conditions are the primary forces that influence the very desire itself. Desire "*(...) embraces them and follows them, shifts when they shift, and does not outlive them. For that reason is so often becomes that the desire to die, whereas need is a measure of the withdrawal of a subject that has lost its desire (...)*" (Deleuze and Guattari 1983:27). When desire is linked to the "conditions of objective existence", it still remains positive force. It can, so to say, 'vanish' because conditions may change but there is still possibility for fulfillment. The fulfillment is always present because to desire is to constantly produce and to produce is to unceasingly create the very fulfillment itself. However, there is one more issue I want to pay attention to, which I define as crucial for the general understanding of desire. Deleuze and Guattari point out that, "*social production is the desiring-production itself*" and that "*the social field is (...) invested by desire (...) and itself stands for "the historically determined product of desire (...)"*" (1983:29). In addition, they also stress that the "*desiring-machines*" are identical in nature to the technical "*social machines*" (Deleuze and Guattari 1983:30). In this

sense they again try to strengthen their conviction of the productive nature of desire and the fact that it produces always and only reality (never fantasies). At the same time, as Eugene Holland emphasizes, “*By restoring the link between desiring-production and social-production (...)*” they argue against the realization “*(...) that psychic repression is somehow autonomous from social oppression, and exists independent of social conditions*” to stress “*(...) that psychic repression (...) derives from social oppression (...)*” (2005:66). However, when the desiring-production is made equal with social-production Deleuze and Guattari immediately emphasize that there is a “*difference in regime between them*” (1983:31). The ways of ‘working’ a key to understanding this difference. The technical machines stop functioning because they “*wear out after transmitting the value to the product*” (Deleuze and Guattari 1983:31). The desiring-machines stop and break but this is in fact to their power and advantage. For Deleuze and Guattari argue that the desiring-machines “*run only when they are not functioning properly: the product is always an offshoot of production, implanting itself upon it like a graft, and at the same time the parts of the machine are the fuel that makes it run*” (1983:31). What is also important is to understand that, as Deleuze and Guattari put it, “*(...) social production derives primarily from desiring-production (...)*” however “*(...) desiring production is first and foremost social in nature, and tends to free itself only at the end (...)*” (1983:35). And yet, for the desiring subject, thus the desiring-machine, there is a possibility of liberating its own desire, creating “*(...) the radically free form of desiring production*” (Holland 2005:66). In the previous section I have already mentioned that the new mode of social production, meaning capitalism, decodes and deterritorializes the flows of desire. “*By substituting money for the very notion of a code (...)*” capitalism “*(...) has created an axiomatic of abstract quantities that keeps moving further and further in the direction of the deterritorialization of the socius.*” Being “*(...) incapable of providing a code that will apply to the whole of the social field*” it makes free desiring-production possible. (Deleuze and Guattari 1983:35). Because of that, as Deleuze and Guattari argue, “*(...) the autonomy of desiring-machines can be restored in relation to the deterritorialized social machine*” (1983:35). Such a situation may occur when the desiring subject “*(...) plunges further and further into the realm of deterritorialization, reaching the furthest limits of the decomposition of the socius (...)*” (Deleuze and Guattari

1983:35). And so, as they conclude the desiring-production starts at the limit of social production, the desiring-production and social production are then end points, and *“between the two there is nothing but an ongoing process of becoming that is the becoming of reality”* (Deleuze and Guattari 1983:35).

The Subject as a “Process”

The subject as a *“process”* is in other words *“body-in-time”* that is an *“embodied and embedded entity”*, *“(…) fully immersed in webs of complex interaction, negotiation and transformation with and through other entities”*. Subjectivity of the subject conceptualized as a *“process”* is a *“process”* itself that, *“(…) aims at flows of interconnections and mutual impact”* (Braidotti 2006:154). This, at the same time, assumes that the human subject, being a *“process”*, is the human subject that constantly becomes. *“To become”* means to not remain the same but to unfold with time, to experience changes and re-arrangements. Furthermore, as Braidotti stresses, *“becoming”* is also *“about affinities and the capacity both to sustain and generate inter-connectedness”* and *“(…) the steps of ‘becoming’ are (…) empathic proximity and intensive interconnectedness”* (2002:8). Her concept of becoming, as she herself emphasizes in Metamorphoses (2002), remains closely linked to that of Gilles Deleuze. For Deleuze, as Cliff Stagoll points out, *“The human subject (…) ought not to be conceived as a stable, rational individual, experiencing changes but remaining, principally, the same person. Rather (…) one’s self must be conceived as a constantly changing assemblage of forces, an epiphenomenon arising from chance confluences of languages, organisms, societies, expectations, laws and so on”* (2005:22). Therefore, for the human subject to be a *“process”* is to become, thus to connect intensively and constantly with surrounding ‘reality’, and as such, undergo constant transformations and metamorphoses. Consequently, Braidotti’s subject is *“non-unitary”* and ‘non-monolithic-like’ but rather multiple, complex, prone to redefinitions and metamorphoses, *“(…) constantly changing and redefining his/her foundations”* (Braidotti 2002:160). Such a subject *“(…) is the effect of the constant flows or in-between interconnections”* (Braidotti 2002:7). In this sense, subjectivity is *“nomadic,” “intensive,” “multiple”* and is seen as *“discontinuous process of becoming”* (Braidotti 1994:101). Thus, to repeat it again, Braidotti’s subject is never, so to say, ‘closed’ and ‘forever-defined’ but prone to endless changes,

transformations, and metamorphoses where affects and desires work as fueling forces, never being less important or less significant than *cogito* and *ratio*.

Power

Speaking about the concept of power, I approach it the way Braidotti (2002) and Deleuze (1983) do, meaning as “(...) *empowering or affirmative (potentia)*” and as a positive force. Discussing power, Claire Colebrook emphasizes that in Deleuze’s philosophy, as in Spinoza’s, to whom Deleuze refers, “(...) *the fulfilment or joy of human life is the expansion of power. Joy [is] the realisation of power (...)*” (2005:215). The Deleuzian concept of power is also close to that of Nietzsche. For Nietzsche, as Colebrook writes, “*There are powers (...) that in their encounter or connection with other powers produce relations, but nothing in the power itself determines how it will be actualised, and any power has the potential to be actualised differently*”(2005:216). Similarly for Deleuze “(...) *there are powers to be, powers that are actualised only in their relation to other powers. So what power is is secondary to its potential (...) if powers are (...) actualised in a certain way, through the particular relations that have been effected (...) powers might be actualised through other relations*” (Colebrook 2005:216). Furthermore, powers can be active which means, as Colebrook explains, that it “(...) *maximises its potential, pushes itself to its limit and affirms the life of which it is but one expression*” and reactive that “(...) *turns back upon itself*” (2005:216). Eventually it is also crucial to mention that for Deleuze “(...) *a being is its power or what it can do*” (Colebrook 2005:216).

The Subject: The “Will-To-Know” and Desire

The “*will-to-know*” is what “*sustains the process of becoming subject*” (Braidotti 2002:160). Desire constitutes an intrinsic element of human subjectivity. Let me apply this to my empirical research with IVF couples.

The Object of Desire

All the Polish and Dutch couples I talked to had a moment in their life when they decided to attempt pregnancy and undertook ‘natural’ efforts to do so. In the previous section when arguing that the human subject is a “play of social and

symbolic forces and relations”, I pointed out the certain motives which caused the couples started to think about mother-and-fatherhood. However, apart from the reasons presented, it appeared that a child stood for the object of desire that resulted from many other elements, different from those of compulsory parenthood. For some couples the idea of having a child was associated with the sense of life itself.

“We could absolutely not have envisioned our life without an offspring” [Ande]

“We could not have imagined not having a child” [Ande]

“The child is the reason for which we live and work” [Ali]

It was also symbolized as the realization of the couples’ teenager’s dreams.

“When I was fifteen years old and I saw pregnant women, I could not wait to have a house of my own and a child. Not work or carrier but what I wanted was to give birth and have a home full of children. It was supposed to be as in love stories, a beautiful wedding and in a moment a baby. It was so important to be pregnant, I could not have waited, I really wanted to be a mom.” [Justy]

“I have always wanted to have a big family.” [Dus]

“I have always wanted to have children. When I was twelve-thirteen years old I wanted to have six children” [Ane]

“We have always loved children.” [Viol]

Some couples saw a child as giving meaning to their lives.

“Life without a child seemed senseless. Such a life was for us all about emptiness.” [Bea]

The possibility of loving a child also constituted one of the elements for which a child became the object of desire.

“I wanted to have a child to be able to love it. It was a need, a need to love. There was nothing more important than that. I needed neither cars nor houses. Those are things. They do not matter.” [Mag]

“It was great to see my husband with other children. He loves kids and kids love him. In those moments, I thought how great it would have been to have a child of our own.” [EI]

“I was wondering especially, at night, why I wanted to have children. Do I want to have children because I love them and when I am in places with children I always want to take care of them?” [Ane]

“We wanted to have children to give love and to feel loved.” [Jus]

Furthermore, a child was seen as a next step on the path of personal development as well as someone to give everything to.

“Finally we were absolutely ready for a child, it was an ideal time, it was a ‘super’ time. We wanted to have it so we could give it all that we had.” [Mon]

“There is a moment to think about having a child, there is a moment for a child.” [Ewsi]

What is more, children were also perceived as the possible embodiment of the couple’s (female/male) imagination of what the proper childhood should be all about.

“Our childhoods were not easy as both of us were growing up without one parent. Therefore, we were dreaming that when we became parents, we would give our child everything that is the best in us for it to have a wonderful life, all we have, all our love.” [Justy and Ande]

“I was a single child so I wanted to have children to let them experience what I could not have and enjoy, in a way, what I could not have.” [Magg]

A child was not only seen as the embodiment of dreams and imaginings, but also as the embodiment of the bond existing between a couple and the living sign of their existence.

“For us the child is a fruit of our love, a mark that we left.” [Ali]

“We wanted to have ‘something’ together” [Dus]

“We wanted to have something in common. When you love someone very much, the child is an expression of this love. We love each other so much that we could have gone on without children, yet to have them was a dream.” [Bo]

“You want to have something of your own; to have something from you and your husband, that we both can share, thus become closer to each other.” [Fos]

For some it was to experience something that they had always wanted to experience.

“I have always wanted to be pregnant. To feel how it is being pregnant. Adoption was not an option.” [Ew, Mal]

“I simply wanted to know how it feels to be a mother.” [Mal, Bea]

To summarize, I would like to say that all those tiny elements, dreams, hopes and imagined scenarios participated in the formation of the couples' object of desire. To put it simply: a child was the couples' object of desire. A child was the object of desire itself.

As I have mentioned, the idea of having a child and becoming a parent was certainly conditioned by notions of compulsory parenthood. However, as I have shown, other motives, or as I call them: elements, also formed an object of desire. When, after a certain period of time, pregnancy could not be established, the couples wanted to know the reasons. Realizing that conception could not take place, some felt upset, some even scared, but the dominant feeling for all of them was the yearning for an explanation.

Productivity: Wanting-To-Know

All the couples both, the Polish and Dutch, that I interviewed, when they were unable to conceive, decided to visit a doctor to find out why conception could not occur. Furthermore, in order to find the explanations for their reproductive difficulties and to clarify the situation, different examinations and tests were undertaken.

“We could not get pregnant so consulting a doctor was a way to find out what was going on.” [Justy and Ande]

“For five years we tried to get pregnant. During this time we visited many doctors and both of us did many tests to know what could be done about our problem.”

[Mag]

“We did many tests and examinations in order to define what our problem was.”

[Ter]

“To do all those tests was the only way to find out what was going on. Thus we did them, my husband and me.” [Mon]

“We were really stressed that after some time of trying there was still no pregnancy. To see a doctor was the only logical solution.” [Lid]

“When we could not get pregnant we started to think about it and became really interested in understanding our situation. We started visiting doctors in order to explain the reasons why we could not have had a baby.” [Bea]

“When there was no pregnancy after one year of trying, we decided to consult a doctor.” [Mia]

“For three years we tried to have a child. Eventually we decided to visit a doctor.” [Bian]

“For two years we tried to get pregnant but nothing happened. We wanted to know what was going on, thus we visited our general practitioner.” [El]

“We tried to get pregnant for five years. Finally, we decided to visit a doctor.” [Jus]

“We tried again and again. One year passed, another year passed then came a moment when I decided to ask my doctor if such situation was ok.” [Ane]

“After one year of trying there was no pregnancy. We worried about that. We waited this one year and when it passed we decided to go and see a doctor.” [Fos]

“We were trying to get pregnant but I was getting older and older. I was thirty-three [I was thirty-eight (male partner)] when we started. My sister was advising me not to wait too long. We eventually went to the general practitioner.” [Tru and Ge]

If the results could not clarify anything, or when after following doctors' advice regarding getting pregnant 'naturally' still the conception did not happen, the couples went back to doctors' cabinets and examinations were repeated in order to again map out the causes and understand the lack of conception.

“For two years since the first visit we were trying to have a baby ‘naturally’ following the doctor’s suggestion. Eventually, together with my husband we looked at the results of our previous examinations and we started to think. We decided to visit a doctor and undergo tests once again to know what to do.” [Justy]

“We were traveling from one clinic to another, from one doctor’s cabinet to another. We were traveling quite long in order to find out what was wrong with us and how we could have got pregnant.” [Mag]

“For ten years we visited different doctors and we both underwent various examinations to understand why we could not have a baby and to know what we could do about it.” [Ter]

“For three years we did various tests and tried to get pregnant. Yet, we could not diagnose which one of us had a problem, me or my partner. The pregnancy really seemed unreachable.” [Pau]

“We were very nervous that we could not have children. After one year of trying we went to a doctor looking for help. For two years we did tests and tried to get pregnant. It did not work. So we decided to look for other clinics and doctors hoping they could do something for us.” [Ali]

“After some time of trying to get pregnant, we realized that there was something wrong. We went through many medical centres, hospitals and examinations to find out what was wrong and to do something about it. We were trying everything.” [Viol]

“After a laparoscopy was performed on my ovaries, we tried to get pregnant for another year. Nothing happened so we went back to the doctor. The results were ok so we tried for another half a year, still nothing. Thus we went back to the doctor again.” [Syla]

“We were trying to have a child but my ovulation was irregular so I went to a doctor. I had cysts and they were removed. We tried again. When after half a year there was still no pregnancy we went to the doctor again.” [Mar]

“For three years we tried to get pregnant then we visited a doctor. Then we were trying for another six months but there was no pregnancy so we went back to the doctor again.” [Bo]

When the causes of reproductive problems could not be explained, and the conception still could not occur, it was a source of anxiety for all the couples.

“We could not find out what was wrong. We were excluding one possible reason after another. It was going on for months. It was so hard, so frustrating because if not ‘this’ and if not ‘that’ then ‘what’? It all lasted for two years.” [Bea]

“The worst was not to be able to find out what is wrong. They told us we should have gotten pregnant but we could not.” [Ali]

“We really wanted to find out which one of us had a problem and what kind of problem it was. To know was crucial because then you can do something about it. So first my partner did tests and later on me.” [Ewsi]

“The worst was not to know why we could not conceive. They could not find any explanations.” [El]

“You want to know what is wrong. If it is something wrong, you want to know that.” [Mar]

Furthermore, all the couples tried to gather all possible information concerning fertility problems, means of overcoming it, and places where they could have gone in order to deal with the experienced reproductive difficulties.

“I was looking for advertisements of medical centers that dealt with these sorts of problems. I wanted to know what was going on and how it could be solved.” [Mag]

“I was looking for information everywhere” [Mal]

“Together with my husband we used Internet to search for information where problems like ours can be explained and solutions suggested.” [Mon]

“When we could not clarify the causes of our problem and the pregnancy was out of stake, we were looking for any kind of information concerning fertility problems. We looked mostly in newspapers.” [Ewsi]

Not only media, but also people met in clinics, or friends with similar problems were treated as sources of information.

“While sitting and waiting during visits to gynecologist I asked women all sorts of questions concerning ‘this’ problem.” [Ewsi]

“My best friend also had problems. She visited one clinic in (...) and encouraged me to do the same as they could really help us. Eventually I called her asking for the address.” [Mon]

“I gathered all possible information on Internet.” [Mia]

“Internet, my sister who was trying IVF, friends, all of them were my sources of information.” [Tru]

Based on the above description I can conclude that the “will-to-know” plays a very essential role in human subjectivity. I want to reason that when ambiguities appear or the situation cannot be understood and comprehended, the need to explain, understand and clarify is essential for the human subject.

Productivity: Desiring

Apart from this need, I want to stress that the human subject is certainly fueled by desires. As explained before, I do not conceptualize desire as situated “on the side of acquisition” where desire is detached from its objects and becomes lack, but “on the side of production” where “desire and its object are the same thing”, and desire equals not lack, but production. In this sense, the production makes/allows desire and its object to be “the same thing”. Simultaneously, the type of production is always conditioned by the type of the object of desire. This is because *“desire is a machine, and the object of desire is another machine connected to it”* (Deleuze, 1983:27). When desire is about production and production is conditioned by the object of desire, then, in the context of the human reproduction, the productivity of desire was reflected in the couples’ constant motion, movement and performed/undertaken actions marked by the type of the object of desire, meaning a child. The couples in question did not stay passive but remained ‘positively restless’ in their everyday behaviour. Desire is also inventive and creative, it is a *“(…) process of composition and assemblage of forces (...)”* (Braidotti, 2006:190) and makes alliances. *“Desire does not begin from lack – desiring what we do not have. Desire begins from connections; life strives (...) to enhance itself and does so by connecting with others desires. These connections and productions eventually form social wholes; when*

bodies connect with other bodies to enhance their power they eventually form communities or societies” (Colebrook 2002:91). The couples did not stay closed in their houses in the void of despair but became creative, building alliances and constantly networking. It was as one Polish couple says,

“Life is a gift, and not to spoil it you must have aims and try to reach them.” [Justy and Ande]

Another one mentions that,

“You simply cannot wait and see what is going to happen; you yourself have to do something about it.” [Ter]

In a similar vein, one Dutch couple emphasizes that,

“You feel ok when you are doing something. It is good to be busy with something. Being active, I had a feeling that I was doing something.” [Dus]

What I have just emphasized can be put into the following scheme: productive desire: motion, movement, action (visiting doctors, undergoing/repeating examinations, gathering information), creativity (gathering information in any possible way, visiting different medical centers), constructing assemblages, building alliances, and networking (talking with friends/people in similar situation) conditioned by the object of desire: a child. If desire can be understood as a productive force and/or production itself, then the anxiety that arose when things could not be explained can be conceptualized as a ‘by-product’ of the couples’ productive desire. As said, desire is about production. It is about mobility, movement and action. Thus, when movement was not possible because no advice was given and no solutions were suggested, what in fact was blocked was the very productivity of desire. This ‘full stop’ was a desire temporarily paralyzed and the result was the anxiety. In this sense, I believe I have managed to present that the productive desire(s) do constitute the subject’s intrinsic and characteristic element(s).

Different Ways to the ‘Understanding’

However, especially for the Polish couples to get to know and to understand was a real challenge. Naomi Pfeffer writes that, “*The investigation and treatment of infertility has long been afforded low status in the medical hierarchy*” (1987:86). She also points out that “*The medical management of infertility has been unpopular with gynaecologists not only because of its intimate and sordid nature but because prior to the introduction of in-vitro fertilization and embryo transfer, those treating infertility could make few claims to special knowledge and treatment*” (Pfeffer 1987:86). Here, I would suggest, lies the problem. As I discussed earlier, in Poland not much has been said and done about infertility and ways of overcoming it. This situation has very important implications and consequences for those struggling with fertility problems. First of all, information concerning infertility and means of dealing with it is almost non-existent and difficult to find. Secondly, fertility problems are handled in a very few, usually private medical centers, whose whereabouts are not easy to track down, and doctors’ qualifications and knowledge (concerning fertility) cannot be in fact verified (see also Chapter Three). Because of this, the Polish couples did not have much choice but to firstly visit the closest gynecologist’s office. This would not have been that bad as it was what basically the Dutch did (the difference was only that they did not go to gynecologist but their general practitioner which has to do with the general organization of the Dutch Health system). In Poland, as said, there is no attention paid to infertility and ways of handling it, to paraphrase Pfeffer “*those treating infertility [still can make]²⁹ few claims to special knowledge and treatment*” (Pfeffer 1987:86). Furthermore, as infertility is mostly taken care of in private centers created without the need for accreditation (see Chapter Three) and that at the same time offer different techniques of assisted conception, general practitioners or gynecologist do not usually suggest treatment there. The point is that those clinics are not usually seen as places where fertility problems can be seriously addressed, but rather as ‘baby-making’ and ‘money-making’ enterprises. As a result, the Polish couples could not expect much from the doctors they turned to, either in terms of constructive, professional advice or in terms of possible solutions. The situation of the Polish couples may in fact serve as an illustration to Lesley Doyal’s (1987) description concerning struggles with

²⁹ Emphasis added.

reproductive difficulties. She emphasizes that, “(...) *many people who are (...) infertile (...) complain above all about the lack of services and the difficulties so many experience in trying to get sympathetic help*” (1987:174). The outcome of such a situation was time lost when being unprofessionally ‘cured’, traveling from one doctor to another, repeating frequently the tests and examinations, taking unnecessary medicines and reiterating different types of medical treatments that later on turned out to be absolutely redundant.

“We were visiting one gynecologist and doing tests for two years. He did not help us.” [Justy]

“I was repeating tests and examinations for quite long,” [Mag]

“During ten years I did many examinations and even artificial inseminations while moving from one doctor to another.” [Ter]

“For three years our doctor tried to ‘cure’ us. Finally, after all this time, he told us that he thought this was probably beyond his qualifications and that he could not help us.” [Pau]

“The general practitioners or gynecologists do not usually give valid information. I was not told that these problems needed special knowledge and that there are other than natural ways of getting pregnant. I did many tests, I was checked for different types of possible diseases, I also had laparocscopy. Finally the doctor told us that he could not do nothing more, but he did not suggest anything.” [Magg]

“For two years we were constantly tested. I had to do hysterosalpinography and laparoscopy. It did not help.” [Ali]

“Six years I traveled through different centers. I had countless blood tests, one hysterosalpinography, three laparoscopies, two artificial inseminations, but no pregnancy.” [Viol]

“For seven years we visited different doctors. Some of them had a very strange attitude. One asked me even to do an X-ray of my skull.” [Mal]

“When we could not get pregnant, firstly I was told that I was too stressed. Later on my husband was given vitamins to make him ‘stronger.’ It did not work.” [Ewsi]

“We went to a gynecologist who advised me to do laparoscopy. I did. Then I took hormones. I felt very sick. We were not told that those sorts of problem should be handled by specialists in this field.” [Lid]

“The general practitioners and gynecologists have no knowledge. They give you medicines you do not need and wrong diagnoses. They do not know and do not have any protocols that have to be followed when infertility is at stake. That was the experience of many our friends.” [Ew]

Situation differs significantly in the Netherlands where infertility and means of dealing with it have been turned into a subject of the debate that has resulted in the organization of specialized medical centers that deal legally and exclusively with these kinds of problems (see also Chapter Three). Due to this, the Dutch couples could not only gather the necessary information, but also obtain professional advice much more easily than the Polish couples. The point is that after the first standard tests such as blood and semen analyses, post-coital test and/or ultrasound scan of female reproductive organs, the Dutch couples were usually sent straight away to gynecologists working either in general hospitals or hospitals specializing in fertility problems with IVF laboratories. When the first is the case, it can be that couples are later on sent to medical centers that can/may perform IVF. Such arrangements prevent couples from making long ‘pilgrimages’ from one doctor to another, having unnecessarily repeated tests and medications; and redundant treatments. Certainly, upon arrival at the gynecologist/fertility center, some tests were done again, yet this cannot be compared to the Polish couples’ situation. The latter ones also had to repeat certain tests and examinations when at the center dealing with fertility problems, but this repetition was one of the many more previously done tests and examinations. The Dutch couples emphasize that,

“I knew how to proceed. For the first visit you usually go to general practitioner. Then you make standard tests. If your results are evaluated as not positive, you are sent at the gynecologist in a hospital where they deal with fertility issues. They repeat all the tests and then certain decisions of how to proceed are made.” [Mia]

”Recognizing that we could not get pregnant after two years, the general practitioner sent us to the gynecologist at the hospital. We had standard tests done and eight artificial inseminations. Nothing worked. Eventually we were advised to go to another hospital that had an IVF laboratory. Upon arrival only blood tests were

repeated and then we were informed as to what the best way for us to continue was.”

[E1]

“After doing some basic tests such as blood and semen analysis, the general practitioner sent us to the hospital. Here the tests were repeated and some additional such as PCT test and contrast were done. We also had six artificial inseminations. When this did not work we were presented with other options.” [Bian]

“I had my cysts removed. We tried to get pregnant, after half a year it was still the same so we decided to go to the doctor again. He sent us immediately to the hospital. Here we had blood, semen analyses, PCT test and contrast done. Later on we started with inseminations. Then we were given other recommendations.” [Mar]

“We waited for one year, then we went to see a doctor. He sent us to the hospital. There we had PCT test and contrast done. We tried again. They sent us to another hospital that had an IVF lab. We again had PCT test and semen test. They advised us artificial insemination. Later we were suggested other options.” [Fos]

“When we decided to visit a doctor, he advised temperature measurement, did a PCT test and semen analysis. The semen activity and quality was very low. He sent us to the hospital. There they repeated the PCT test, ultrasound scans, semen and blood analysis and we were advised artificial insemination.” [Tru]

“After one year and a half of trying, I was around 30, we went to a doctor. He sent us to the hospital. They did contrast, semen and PCT test. The semen activity was very low. They suggested inseminations. Nothing happened and they gave us other suggestions. However, I did not have good feelings about this hospital and we went to another one.” [Dus]

“After many years of trying we went to a doctor. We had to measure temperature, and had blood and urine tests done. Then we went to see specialist in a hospital. They did contrast, ultrasound scans, semen analysis, and a PCT test. The results were ok but they found something in my uterus and I had an operation. Yet we did not like the way my partner was treated, so following the advice of our friend, we changed hospitals. There we had artificial inseminations but they did not work and we were presented with other options.” [Ane]

It is absolutely crucial to emphasize that neither the Polish nor the Dutch couples saw those factors as barriers or reasons to stop or to give up. At the same time, the moment explanations could finally be delivered, they experienced relief.

“I would have rather known what was wrong than not, because otherwise maybe you had a feeling that it was inside of your head. I was really happy that there was something because at a certain point you really start doubting yourself and you think that it must have been ‘between my ears’.” [Dus]

Furthermore, with concrete advices given and the chance for possible solutions, the anxiety was significantly diminished.

“When we arrived to the clinic we felt that finally we would know more and that something would be done about our problem.” [Justy and Ande]

“The clinic was the place where we knew someone could help us to understand, give us advice, tell us what could be done, and so help us.” [Mag]

“In the fertility clinic, for the first time in the six years, I was given concrete and solid advice and suggestions. I was so happy. I felt that we finally would get help and something would be done. I knew that here my dreams could come true.” [Viol]

“To be in the hands of specialists that know what they are doing, means a lot.” [Lid]

“The clinic was the place with ‘the beginning and the end.’ Professionalism and Professionals. They told you we start here; we finish there. Then you know you have a chance.” [Ew]

“For the first time we ‘saw sense’ in what the doctor was talking about. He knew what he was talking about and we hoped soon we would know, too.” [Ewsi]

What I have presented once again supports the statement that the “will-to-know” is crucial and intrinsic to the human subject. The experienced feelings of relief signalize the “will-to-know” as an essential element. This is because the moment explanations and advice were delivered, relief came immediately. Such situations also support an argument that the subject is fueled by desires being about nothing else but productivity. The diminished level of anxiety when something was explained or suggested can be taken as evidence that desire(s) are essential for the subjects. As

desire is about productivity, the moment it got unblocked and possibilities of movement and action appeared, the anxiety could be reduced. Therefore, I can conclude that the human subject definitively possesses the “will-to-know” and desire and that these things work to fuel the subject. Desire can also thus be seen as a positive, productive force of creation and action.

The Subject: The “Will-To-Know” and Desire

The Importance for the IVF Debate

The realization that the “*will-to-know*” “*sustains the entire process of becoming-subject*” (2002:160) and that desires do play an essential role in human subjectivity is of utter importance the moment in vitro debate starts. With the comprehension that the ‘craving’ for an explanation and understanding is intrinsic to the human subject and that desires fuel humans more positive but also more accurate evaluation of in vitro technique and practice (than the one of the radical feminists and the Vatican) is possible to produce. The assessment can be more accurate as by including the importance of the human’s “will-to-know” and desires, the whole evaluation certainly becomes more complete. When the human subject’s “will-to-know” is taken under consideration, it becomes possible to confirm its share in creating the situations where different doctors and clinics were visited and a great variety of tests were made. At the same time, all visits, clinics and undergone examinations can be evaluated as the means and particular ways that could lead to understanding and comprehension. The radical feminists and the Vatican both worry about woman and man losing control over reproduction. However, I would like to argue otherwise. The moment the importance of the “will-to-know” and desires is focused upon a different conclusion is possible. What I want to suggest is that doctors, clinics and tests should not automatically be assigned controlling, and as such abusive, features. In fact, it can be contended that doctors, clinics and various examinations are used as instruments and tools. Tools that will actually allow couples to understand and to act further, which on the other hand, indicates that they are in control and become empowered. Furthermore, when it is realized that the productive desire is intrinsic to the subject, then it becomes obvious that all visits, clinics and examinations signify the productivity of desire. What is more, when it is comprehended that visits and tests stand for the productivity of desire (process of production) conditioned by the

object of desire (a child), it can be concluded that they constitute an “*integral process of desire*” (Ross 2005) and occur on the “*desire plane of immanence*” (Deleuze 1983, 2001) and as such do not ‘belong to the outside world’. Therefore, the radical feminists statements about fertility clinics (and the methods offered there) being alluring because of promises to fix problems (giving a child) and thus be abusive, do not seem to be correct ones. It seems to me that with desire and desiring-production taken into consideration, it can be argued that those clinics/medical centers and what is done there, cannot be assessed as alluring. This is because they (together with their promises) do not stand on the “side of acquisition” but production. They do not function and perform beyond the “immanent plane of desire” in the sense that tests/examinations/clinics are equal to the productivity of desire and to the object of desire. They all happen simultaneously, on the same plane of immanence, and at the same time, they all belong to and form the same plane of immanence. Furthermore, when the tests, examinations and visits to doctors are approached as desiring-production, as the desiring connections when “*bodies connect with other bodies to enhance [and expand]³⁰ their power*” (Colebrook 2002:91) then once again, I can oppose their abusive and controlling ‘nature’ and grant them rather empowering characteristic.

Furthermore, by appreciating that the “will-to-know” and desires are intrinsic elements of the human subjects, more accurate approach to new reproductive technologies/practices can be proposed. The non-approval of technologies will not stop people from desiring – meaning – producing thus acting/moving/doing. Therefore, I will again repeat that the non-approval of IVF technique will not benefit anyone, especially those struggling with fertility problems. Instead, I want to stress, that efforts should be undertaken to assure that the productivity of desire is the optimal one and to diminish the possible augmentation of anxieties and dangers.

What is more, with the “will-to-know” and desires seen as crucial for the human subject, the concept of the IVF clinics and their offers may be transformed. They can be conceptualized not as alluring, controlling and oppressing, but on the contrary, merely as tools, modes of agency, regained control and empowerment. Furthermore,

³⁰ Emphasis added

their functioning can avoid the notions of allurements, seduction and as such of the abuse.

The Subject: The “Process”, Negotiations, Power and Desire

“The subject is a process, made of constant shifts and negotiations between different levels of power and desire, that is to say wilful choice and unconscious drives” (Braidotti 2002:160). Braidotti states, to repeat for a moment, that, *“the subject is a process, made of constant shifts and negotiations between different levels of power and desire, that is to say wilful choice and unconscious drives”*. Here, I would like to go back to the concept of power I discussed at the beginning of this section. Power is what is done. It is this very “wilful choice”, the actualization of potential, conditioned by “other powers” and actualized in relation to them. In this sense, different levels of power mean the share of “other powers” in the final process of actualization. If then the “other powers” are conducive it can be that the actualization, that is the “wilful choice”, can be equal to the productivity of desire, in which the object of desire has its share. If the “other powers” are hostile, the “wilful choice” will remain in opposition to the possible productivity of desire with the mark of desire’s object in it. Thus to be “made of constant shifts and negotiations between different levels of power and desire”, is to perform actions that stand for the productivity of desire or their opposites. This, I want to argue, also indicates negotiations that take place between the ‘other powers’ and the object of desire which, to repeat, either lead to productivity of desire or actions opposite of it.

The object of these couples’ desire was a child. The fact that the Dutch and the Polish couples (though, as presented, in the latter case it took much more time) ended up in the fertility clinic(s) signified/stood for the productivity of desire and the desiring-production. However, when in the fertility clinic, the only way for the productivity of desire (when the object of desire is a child) to happen was to follow doctors’ advice and go on with examinations and different types of recommended treatment. The “other powers” were convenient (place, adequate equipment, acquainted with the matter doctors) thus the decision to agree upon given suggestions and to go on with recommended tests was made in all the cases.

“Being in the clinic we felt that this is” the place,” the place where we can get pregnant. We went on with various tests such as laparoscopy and PCT test but also artificial insemination. We did it all desiring to have a child above anything else.” [Mag]

“The clinic was the place to try once again to get pregnant. It looked very professional. Having this chance we did many tests together with artificial inseminations.” [Ter]

“For three years nothing could be done. In the clinic there were real possibilities of becoming pregnant thus we followed the advice and did artificial inseminations five times.” [Pau]

“We knew they could help us so we did ultrasound scans, hysterosalpingography, laparoscopy, ovarian surgery. We did them as we had this opportunity and because that was the only way to be able to eventually get pregnant.” [Ali]

“To go on with tests and artificial inseminations was the only chance for pregnancy. Being in a clinic we had to take this chance.” [Bea]

“To be in a clinic was to have a chance for pregnancy and at the same time a great opportunity to ‘get there.’ To do all those tests was the best we could do. So we did: blood tests, PCT test, hysterosalpingography, laparoscopy, immunological tests, eight artificial inseminations, etc.” [Ewsi]

“You spent lots of time at the hospital. We did semen and blood analyses, hysterosalpingography, PCT test, many ultrasound scans, and we had six artificial inseminations. I had no problems with injecting myself. We were all right doing this because we felt that we are doing something to reach our goal. We were doing something to have a child.” [Mia]

“It was ok to do all those tests. It made you to be closer to your own child.” [El]

“None of the tests were nice, but I felt it was necessary. You want to have children, so you do them.” [Mar]

“At the beginning you do not like someone examining you. You feel you do not want it. Yet the child is something you really want so at some point you eventually got used to that.” [Fos]

However, though the place, equipment, doctors and medicines enabled the productivity of desire, there were cases when couples decided not to take advantage

of them. The object of desire, a child, remained the same, the situation (“other powers”) was convenient (place, adequate equipment, acquainted with the matter doctors) and yet the eventual decision, the “wilful choice” was either to terminate or not to follow examinations, tests and recommended treatments. That was because the ‘conditions’/“other powers” were not all together that satisfactory. In all the cases the decisions to terminate or not to follow what was recommended was determined by the fact that either there were physical side effects, or anticipation of such, or fear of no results whatsoever.

“We were following the doctor’s advice hoping for pregnancy. However, the prescribed medicines that I was taking gave me headaches, acne, insomnia, and anxiety. To stop them was my idea and I did stop taking them. [Mia]

“I think we did all the possible tests and examinations, took countless medicines and went through various treatments. We did blood tests, immunological tests, post-coital test, ultra sound scans, hystersalpinography, and laparoscopy. I took hormones but also injections that were made from someone else’ blood. We also did many inseminations. Nothing worked. We had had enough. We stopped for one year. Before that I also refused to take prescribed medicines. I heard they could cause cancer. Then I thought’ thank you very much for giving me a child and a cancer.” [Ewsi]’

“At first we decided to do artificial inseminations without hormonal stimulation. I was simply afraid of how hormones could have affected my health.” [Mia]

“When eight artificial inseminations did not result in pregnancy we were advised IVF. Yet, we did not go for it immediately. We took a break.” [El]

“I wanted to go on with IVF but we stopped for a long time as I had severe problems with my shoulders.” [Bo]

“I had a miscarriage after the first IVF try. I wanted to go on, but at the same time I had problems with my tooth and I needed an operation. I did not want to do two things at the same time, thus I postponed the second IVF try.” [Ane]

There are constant negotiations between the “other powers’ and the subjects’ object of desire. The particular course of action (participation/non-participation in tests) is performed because of existing ‘conditions’/“other powers” (convenient place/side

effects/no results) in the interaction(s) with the object of desire, which in the context of reproduction stands for a child. Thus the subjects' actions sometimes stand for the productivity of desire and sometimes remained in opposition to it. In this sense, I can argue that the "subject is made of constant shifts and negotiations between different levels of power and desire, that is to say wilful choice and unconscious drives". Furthermore, I can also contend that the "subject is a process", who constantly becomes in a sense that it changes, re-arranges and as such never stays the same. The subject unfolds and undergoes transformations (pursuing/terminating examinations and treatments). This happens because to become is to interconnect and to turn into assemblages of forces (convenient time and place, proper equipment, doctors, physical side effects, no outcomes/results.) As such the becomings, and so the subject, stand for an outcome of "*empathic proximity and intensive interconnectedness*" (Braidotti, 2002:160) and "*an epiphenomenon arising from chance confluences of languages, organisms, societies, expectations, laws and so on*" (Stagoll, 2005:22).

To give an even better illustration to the statements have made, I want to point out two very important phenomena. The first has to do with the application of the IVF method and the second with the situation(s) just before and during the performance of the method itself. Concerning the first phenomenon, I want to stress that there was a moment when the decision of how to proceed further had to be made by all the couples. The productivity of desire (where the object of desire stood for a child) reflected itself in all the initial examinations and treatments such as laparoscopic ovarian surgeries or artificial insemination. At the same time, there were possibilities to act in such a way as to obtain the desired pregnancy. However, in some cases the test results indicated that establishing pregnancy 'naturally' would be extremely difficult. In other cases the advised and performed treatments (laparoscopy; artificial insemination) did not have an outcome in conception. There were also cases when it was known from the start that 'natural' conception was out of reach (no spermatozoids after chemotherapy; removed fallopian tubes). All the couples were faced with the decision to either step back hoping that sooner or later the pregnancy would somehow occur or to try human in vitro fertilization. The object of the couples' desire did not change and there were possibilities for the productivity of

desire to take place (money, medical facilities such as: doctors, proper equipment and IVF method). On the other hand, living without a child was anticipated to be very difficult, other methods such as artificial insemination did not work and the possibilities of becoming 'naturally' pregnant were beyond the reach. Having a child as the object of desire, having conditions for the productivity of desire to occur (i.e. IVF method) recognizing that the other methods did not work, realizing the difficulties of the 'natural' conception, the fact of aging and anticipating the quality of childless life, the couples eventually opted for participation in human in vitro fertilization ("wilful choice" equal to the productivity of desire).

"The doctor told us that there were no spermatozoids in my husband's semen and that we had no chances for pregnancy after sexual intercourse. We both wanted to have a child so much. We knew that at the clinic they could help us. We knew they had a sperm bank we could use. Taking this all under consideration, we eventually decided to undergo the IVF procedure." [Ter]

"I wanted to have a child of my own desperately. I wanted it so badly. After doing tests it turned out that my husband's spermatozoids could not make it. It was something between us that did not work. We could have proceeded with inseminations but there were no result and no results. We did not want to lose more time. In this situation, to try IVF seemed like the best thing to do." [Mag]

"It was difficult to define what was wrong. We did five inseminations. Nothing worked, time was running out, and I could not imagin my life without a child. We went for IVF." [Pau]

"After doing tests it was obvious that my husband could not have children. I wanted to be a mother. I wanted to have a child with no one else but my husband. The clinic was offering such a possibility. We decided to go for it." [Mon]

"My results were ok. It was my husband that could not have children. We did many inseminations. Nothing worked. I did not want to live without a child and I did not want to leave my husband either. 'Natural' pregnancy was not possible. Inseminations did not work. IVF was something that could work." [Magg]

"To live without a child? We could not even think about it for a moment. Our results were not good and no one could say what was wrong. We did genetic tests, my husband took medicines, I went through hysterosalpinography and laparocopy.

Nothing. We could have waited for natural conception. It could be possible, the doctor said. But we did not want to wait, we wanted a child thus we went for IVF.

[Ali]

"My husband had cancer; we knew that we could have problems. We both did various tests. We both went through inseminations. Nothing. To participate in IVF could give us a child. We both decided to go for it." [Ew]

"I could not live without a child. It would be a senseless life. Adoption was not an option. My husband's results were very bad. Inseminations were not successful. IVF was then an option." [Mal]

"Seven inseminations and no results. A childless life seemed like a nightmare. IVF could still be a chance." [Bea]

"Tests we did showed that we should have gotten pregnant 'naturally.' Yet, inseminations were unsuccessful. We took a one year break but pregnancy did not occur. We were back at clinic and again we started with inseminations. After four more, we had had enough. Desiring a child, being tired of 'natural' tries and inseminations, I asked the doctor if we could maybe try IVF. He replied that it was an option." [Ewsi]

"We did six artificial inseminations. Nothing worked. Living the way we lived was impossible. You cannot plan your life. You do not plan big trips. You do not plan going abroad because everything can change if you get pregnant. You cannot plan more than one month ahead. Thus, you are always in limbo. You are always in waiting. It is never ending. To do IVF was to try to find the way out." [Mia]

"I had one fallopian tube removed. I was supposed to be examined, but in the meantime I got pregnant. The pregnancy was again developing in my fallopian tube. It had to be removed. I had no fallopian tubes left. In this situation I accepted the idea of doing IVF." [Mari]

"They told us that the quality of my husband's semen was low. For six years we could not get pregnant. We wanted a child so much. The IVF seemed to be our opportunity." [El]

"It all took five years. Nothing worked. We were really desperate. We did not want to live with a wish for a child. It is the only thing that occupied you. Vacation, work, you could not give enough energy to that. It was always at the back of your mind. IVF was the opportunity to not live like that." [Bian]

“They could not find anything. We were advised to try to get pregnant naturally, but there was no pregnancy. They repeated tests and said that the semen quality was low. Yet, they still suggested getting pregnant naturally. It did not work. Later we had six inseminations, they did not work either. We wanted to have children. We could not imagine life without children. Eventually you only thought about pregnancy but you also wanted to enjoy your life. Thus, IVF was our last chance.” [Fos]

“We thought we would have children the ‘normal’ way. I had polycystic ovaries. They were operated but still I did not get pregnant. We were trying for almost six years. Eventually IVF appeared to be our only possibility of conceiving.” [Syla]

“We had six artificial inseminations nothing worked. The doctor told us that the chance for natural pregnancy was very small. I was thirty-four years old that time. That was the moment we decided to go for IVF.” [Mar]

“We tried, all together, for nine years. They could not find reasons. We had four inseminations. Nothing worked. I was thirty-four by this time. IVF seemed to be our only option.” [Bo]

“We were getting older; the semen quality of my partner was low; eight inseminations did not work, and we wanted to have a child. IVF appeared as an option.” [Tru]

“For many years we tried to have children. Nothing happened. Then we had six artificial inseminations. We were so sure it would work. I was really scared; so what now? I was thirty-nine years old at that time. IVF was the only opportunity we had left.” [Ane]

Regarding the second phenomenon I want to point out the moments when (1) IVF technique was just about to start and (2) when it was already taking place. Though the object of desire (a child) was constantly present and the productivity of desire had a good environment to thrive in the couples acted in a way that was, objectively speaking, against the desiring-production. That was because the “other powers” mattered equally. The actions I want to refer to have to do with the performed type of IVF technique such as Classic IVF and IVF-ICSI (for details see Chapter Three) and the number of fertilized egg cells and transferred to uterus embryos.

Some of the Dutch couples who participated in IVF technique did not consider more advanced and scientifically defined as more ‘successful’ IVF-ICSI to be an option.

“It is a bit ‘unnatural.’ Artificial insemination is ok, IVF less but IVF-ICSI we will never accept. The first IVF try for the second child did not work out. There were no embryos due to infection. I could believe that. I wanted a child even more then before. They proposed IVF-ICSI yet we could not do it. We actually wanted to stop.”

[Fos]

“I knew IVF-ICSI was not my thing. If IVF had not worked, we would stop.” [Dus]

Some other Dutch couples also strictly determined the number of egg cells to be fertilized and number of embryos they wanted to be transferred back.

“We wanted only one embryo transferred. We did not want to risk with twins. It was risky.” [Bian]

“What happened with embryos was not ok with us. Thus, we determined the number of embryos. We only wanted two embryos created and two transferred back.” [Jus]

“We only wanted two eggs fertilized and two embryos put back. It is in our religion.”

[Fos]

“They asked me if I wanted to go for an investigation when they put more embryos back. I decided I did not want to because I was almost forty and I thought it is too big a risk and I did not want that.” [Ane]

The desiring-production could have taken place and yet personal beliefs/convictions/preoccupations did not allow choosing options that, according to the medical field, could have increased chances for pregnancy. Interestingly enough, decisions of this kind were never made by the Polish couples. Quite to the contrary, in most of the cases IVF-ICSI was chosen as a conceptive technique. Furthermore, the couples wanted the highest possible number of egg cells to be fertilized and the highest possible number of embryos (that is three) to be transferred back. Life without a child was evaluated as senseless and the possibility of choosing IVF-ICSI and having the highest number of embryos created and transferred could increase chances for pregnancy. Therefore, the decision appeared to be simple. However,

there was more to that: meaning the financial factor. The object of desire (a child) mattered, opportunities to act were there, but so was a fear that if Classic IVF would have not worked and ‘smaller’ number of embryos would not have developed into foetal stage there could have been no money for the next try. Therefore IVF-ICSI and the highest numbers of embryos were usually opted for.

“To gather money was a challenge. It took us two years to start. We chose ICSI as it gave us more chances. I am not sure if we were not successful, we could have repeated the whole procedure.” [Ter]

“We decided to do ISCI to increase our chances” [Mag]

“We had very little money so we decided to do ICSI as it is a better method than normal IVF. We also asked for the highest possible amount of embryos to be transferred. We were afraid of a failure, the impossibility of repeating the procedure and so of having our child.” [Ali]

The Subject: The “Process”, Negotiations, Power and Desire

The Importance for the IVF Debate

When the human subject is approached as *“a process, made of constant shifts and negotiations between different levels of power and desire, that is to say wilful choice and unconscious drives”* (Braidotti, 2002:160) then a more accurate evaluation of IVF technique/practice becomes possible. What makes the assessment more adequate is the possibility of delivering a more complete picture, of realizing the human’s ability to negotiate and so, not to follow blindly whatever is offered even if to go for it would equal productivity of desire. Seeing the subject as being made of negotiations and shifts, recognizing ‘dialogues’ that take place between “other powers” and the object of desire, confirming the subject’s flexibility and transformative possibilities also allows conclusions to be drawn which are different than those of the radical feminists’ and the Vatican’s. To perceive the human subject as one that unfolds and changes over time, not being frozen in the stillness of one life frame; to see it as endlessly experiencing various encounters, interactions and interconnections, is to be able to produce a much more positive assessment of human in vitro fertilization.

To acknowledge that the subject is made of negotiations and shifts is to acknowledge three very important things. First, that the actualized power, so the subject's "wilful choice" sometimes can be equal to the productivity of desire and sometimes remain in opposition to it. Second, that productive desire is an utterly important force, yet the subject's actions do not necessarily need to reflect in themselves the object(s) of desire. Third, that, as Colebrook writes, "(...) powers are actualised only in their relation to other powers (...) are actualised in a certain way, through the particular relations (...)" (2005:216). Made of negotiations and shifts, the human subject may but not necessarily go for desiring production that bears the mark of the object of desire (participation in examinations, IVF method) or performed actions opposite to it (termination of tests, participation in certain type of IVF technique, strictly defined number of fertilized eggs and placed back embryos). Therefore, statements that suggest that with development of alternative methods of conception, couples will not be able to say no or negotiate with technological promises, or that they will certainly lose control over reproduction, do not seem to be all together proper. Such recognition also allows a conclusion that IVF technique is not chosen just because it exists or that it will always be chosen, no matter what. In this sense, the statement that new technologies will make people immediately go for them and, on this basis, to assess them as abusive also does not appear to be correct. The object(s) of desire matter. Productivity of desire can take place, but other inputs (i.e. Colebrook's "other powers"; Deleuze's "conditions of objective existence") matter too. The comprehension that "other powers" do matter (as there are negotiations between "other powers" and the subject's object of desire) allows one to understand that the "actualisation of power" (the choice of 'less' advanced IVF method, smaller amount of made and transferred embryos) may be conditioned less by the object of desire than by those "other powers" (i.e. beliefs/convictions/opinions). It is as Naomi Pfeffer writes that, "*Men and Women have clear limits beyond which they will not venture. Some will not consider artificial insemination using donor semen, others refuse in-vitro fertilisation whilst yet others reject adoption. Such limits are not evidence that some people's motivation for parenthood is insufficiently strong. Rather, these limits highlight the real social differences that exist among infertile women and men*" (1987:84). In this sense, I can again oppose the radical feminists' and the Vatican's statement that new techniques if proposed, are irresistible, will

always be chosen and will cheat couples off their reproductive control. It also does not seem that new reproductive technologies/practices change prospective patients into victims or passive marionettes as the couples apparently did not follow wordlessly and without resistance whatever doctors suggested or recommended. Seeing the subject as the one that negotiates, as the one that becomes different depending on the assemblages of forces it encounters and is a part of, permits the realization that the subjects do maintain their agency and that participation in IVF technique is the outcome of those very negotiations and becomings. It was only when nothing else worked, when 'natural' tries or artificial inseminations failed, that some couples explicitly asked for IVF technique (agency maintained) and decided to participate in it (outcome of negotiations and becomings). New encounters and different assemblages of forces create new becomings. Negotiation between "different levels of power and desire" result in certain actions. With the above realization, the feminists' and the Vatican's statement that users of reproductive technique will lose their agency and that IVF will make people opt for it right away, does not seem to be easy to prove. In addition, the suggested manner of approaching the human subject also permits seeing the woman's position differently when it comes to assisted reproduction. Realizing that the subject is made of negotiations between "different levels of power and desire" it is possible to reject the statement that woman is a victim of 'technological-man-doctor-driven' oppression when it comes to assisted reproduction. IVF technique is chosen ("wilful choice"/productivity of desire) because of the "other powers" (anticipated life without a child, impossibility of getting 'naturally' pregnant, possibility of having a chance) and certainly the object of desire (a child), and not just because she is made to or feel obliged to do so. The women considered their various options and only when all the elements were considered they acted accordingly. Even if participation in IVF technique has to do with the male partner's inability, it is not to be automatically concluded that a woman becomes a victim. It is the productivity of desire enabled/stimulated by "other powers", that encloses itself in performed actions (participation in tests, IVF technique) All in all, I can conclude that it is crucial indeed, to see the human subject as "made of constant shifts and negotiations" because it promises a more accurate and, in fact, a far more positive evaluation of human in vitro fertilization.

To see the human subject as “made of constant shifts and negotiations” equally allows the proposition of a more adequate approach to human in vitro fertilization. To see the human subject in the proposed way is to realize, which I have already emphasized, that the productivity of desire may or may not take place. This, to a great degree, is conditioned by the “other powers”. When the object of desire (a child) is intense; when the “other powers” (anticipation of life without a child, impossibility of getting ‘naturally’ pregnant; possibility of getting pregnant with technological assistance) are there, then the productivity of desire (where the object of desire is a child) takes place (participation in IVF technique). At the same time, the productivity of desire goes hand in hand with the “wilful choice” (participation in IVF technique) where the latter can be defined as optimal in the given context (place, space, time).

“IVF was our last chance to become pregnant.” [Justy]

“In our situation, IVF was the final help we could have obtained.” [Mag]

“If anything could give us a child, it was IVF.” [Ter]

“IVF? The last chance. That was what it was for us.” [Pau]

“The last chance. The last possibility. The final hope for help.” [Ali]

“With my husband having had chemo, IVF was the only solution for us.” [Ew]

“IVF it was the last possibility of having a child.” [Bea]

“To do IVF was to do everything that was possible.” [Mia]

“With two fallopian tubes removed, IVF was the only chance. There was no other way for us but through IVF.” [Mari]

“IVF seemed to be our last option, our last chance, our opportunity to get pregnant and have a child.” [El]

“IVF was a last chance for us.” [Bian]

“After nine years of trying, IVF was our last option, the last chance.” [Bo]

When then the fact that negotiations do take place, and so the performed actions are born on the crossroads of “other powers” and object(s) of desire, then to emphasize that reproductive techniques should not be approved does not seem to be a good idea after all. Not to approve technology, as I have already said in the previous sections,

will not stop people from launching desiring-production. Therefore, not non-approval but rather the optimal shape of the productivity of desire should be assured.

Eventually, in the framework of the negotiating and becoming subject, the notion of IVF technique produced by the radical feminists and the Vatican has chances for re-conceptualization. First of all, IVF does not seem to be an irresistible, alluring and abusive technique. Secondly, to see this method as being all about absolute control over human reproduction does not seem correct either. Thirdly, those new techniques such as IVF can be conceptualized as the last chance, where the expression 'last chance' does not indicate a couples' passivity, subordination and/or desperation. IVF technique defined as the last chance signifies that participation in this procedure is an optimal one, born from negotiations and different assemblages of forces where becoming takes place. Due to that IVF technique conceptualized as the last chance is not a container for the negative but it can have quite positive connotations.

The Subject: Desire versus "Rational Judgement"

Braidotti writes that desires "*play as important and constructive role in subjectivity as rational judgement*" (2002:160). For the oncoming discussion, it is crucial not to forget that whatever desire is, it does not lack anything. On the contrary, desire and its object are the same thing, one machine connected to another. It is also essential to keep in mind that desire is about productivity, intensity and qualifies as a positive force though linked to the "conditions of objective existence". Furthermore, it should be remembered that the process of desiring is the process of constructing assemblages. In addition, it is equally important not to forget that desiring-machines may stop and break, however only to their power and advantage, but also they can liberate their desires (Deleuze, 1983).

Difficulties Not Only of the Physical Kind

Many of the Polish and the Dutch couples I talked to mention that participation in IVF technique requires as Naomi Pfeffer writes, "*(...) men and women to lay bare their sexual selves for judgement and manipulation by the medical profession*" (1987:86).

"It is not nice when a couple of doctors look between your legs." [Justy]

"It was not easy to lay there. You are in the chair, your legs up, and so many people around you. It is difficult to say, but I guess it was not feminine." [Mon]

"You had to undress. You had to lay on one of the gynecologist chair. You had to wait for the gynecologist to do different things. Later, you had to do it again. That was a hard part." [Mia]

"When you laid down on the table, prepared for an echo, it was not nice. It was not nice lying naked." [Tru]

"The production of semen was awful." [Fos]

"It was difficult to 'produce' semen" [Tru]

The couples also stress that to go through the IVF technique can be physically painful and the pain was sometimes very hard to endure.

"I cannot say that there was no pain. There can be lots of pain actually." [Pau]

"It was very difficult to stand all this pain sometimes." [Mal]

"There were moments I felt lots of pain and the pain was sometimes unbearable."
[Bea]

"I cannot say that the medical procedures were nice." [Magg]

"What you needed to go through can be physically painful." [Ali]

"Sure it hurt sometimes. It was not nice to feel pain especially if you are very sensitive to pain." [Ew]

"I could not stand the pain sometimes. It was awful." [Ewsi]

The IVF technique is described as physically painful and unpleasant especially when it came to hormones and injections.

"I hate needles so injections were very difficult for me." [Tru]

"Injections were a difficult part. I did not like them so it was very hard for me to do them. Stimulation was difficult. I had to take more hormones. I had headaches."
[Mar]

"I started to take hormones. It was awful. I gained sixteen kilos. I was very unstable." [Ane]

“I really did not feel good taking hormones. I had terrible headaches.” [Jus]

The Dutch female participants also refer to egg cell aspiration as a painful method as in The Netherlands it is done without anaesthesia.

“It was very painful. I have never had so much pain in my life. It lasted for almost forty five minutes. I felt horrible.” [Mia]

“The aspiration was awful. It was very painful. I was screaming. I could not walk afterwards.” [Mari]

“They took two eggs, with the last, the third one they told me it would have been painful. At one moment I took a deep breath and afterwards I said to them ‘That was not nice.’” [Tru]

“The aspiration was really terrible. I did not like it at all. Horrible.” [Fos]

The IVF technique is also described as a dangerous one.

“I had overstimulation of ovaries. I was really ill. I woke up with a terrible pain. I suddenly gained twenty kilos. I could not move. It was a life threatening situation. I was really sick.” [Mia]

Pursuing with IVF

Having presented the above descriptions, I can certainly argue that the *ratio* was never out of the picture. Even if they did know at the beginning what could be expected, the couples very quickly realized how demanding IVF technique was, physically as well as mentally. Yet, for all the couples I talked to, those were not reasons to reject participation in IVF. This signals that even if a judgement based on rational arguments was present, so was the productive and positive force: desire. I have already emphasized that desire is about production as it is a machine with the object of desire being another machine connected to it (Deleuze 1983). Thus, when, in the context of human reproduction a child stands for the object of desire, participation in IVF technique stands for the desiring-production. In this sense, doing IVF technique equals the productivity of desire and signifies that desire is intrinsic to the human subject indeed.

“Even if it hurts, you do it. There was no life for me without a child, so even if it is painful you go for it. If it had not been successful I would have done it again and again and again.” [Mag]

“Even if it is not too ‘feminine,’ even if you do not like it, you do it because doing it is like ‘getting’ a child.” [Mon]

“There were moments when you felt humiliated because you needed to be completely ‘open’ but we closed our eyes onto that. Wanting a child above everything else, we were not analysing, we were doing.” [Magg]

“Going for IVF is to have a child. The child will not come ‘out of the air’ so you simply do it.” [Justy]

“If you want a child, you do whatever is needed to have one. You just do it. IVF it is something you simply need to do, and so you do.” [Ter]

“Nothing could have stopped me. To do IVF, to go for it, meant to have a child.” [Mal]

“You do it, if what awaits you is a child.” [Bea]

“If you want to be pregnant you do everything that can be done. If this means IVF, then you do IVF.” [Ew]

“When you want to reach your aim, you need to do something. You need to do this, you do it. You need to do that, you do that as well.” [Ewsi]

Desire and the desired object are the same thing (two connected machines). Desire is about plenitude, it is a productive force, it makes and creates things (Deleuze 1983; Braidotti 2002; Grosz 1995). I want to argue, that being a positive force, (Ross 2005), desire is also about joy and delight. When the object of desire is a child, then participation in IVF stands not only for the productivity of desire, but it (participation) is also constantly sustained by and creates positive feelings and emotions. Thus the very fact that the couples were going through and going on with IVF technique and actually enjoying the possibilities of the action, points to the constitutive role of the productive desire in human subjectivity.

“If you want something really badly you can stand everything. If you want a child, you simply can go through it all, it does not matter what. Doing it is being closer to your child.” [Viol]

“Even if it hurts you do not bother much about it because what matters is the final result: the pregnancy. It is not important that you feel pain. You want a child, that is your aim, so you go through it.” [Ali]

“Some things are not nice, but you want children so you do them.” [Mar]

“If you want something, if what you want is a matter of life and death, then you can ‘move mountains’.” [Pau]

“It all was tough yet once you are in it, you go on. It does not matter. What fuels it all is a child.” [Bo]

“When you want a child there is nothing that can stop you and so you go on, go on, go on.” [Pau]

“You go with a flow. You go further. It just goes. You want to have a child.” [Dus]

“When you start you go on. You just go on, you can go through it.” [Ewsi]

“When you are in ‘it,’ you go on.” [Bian]

“When you start you go on.” [Jus]

“The ability to do, to act, to go on is a real happiness.” [Pau]

Waiting and Anxieties

According to Deleuzian concept of the productive desire, desire constantly produces and is all about production. Waiting is not. Thus, I want to argue that if something stops the desiring-production (such as waiting does), it is not surprising that anxiety follows. When anxiety appears, I want to argue further, from the ‘blockage’ or ‘non-production’, this indicates that there was movement and production and that this movement and production are most valuable. Following argument, the anxiety caused by the ‘blockage’ points to the realization of desire being the most important fuel intrinsic to human subjects. In this sense, the anxiety or hardships experienced (when the couples needed to wait in order to be admitted for the various treatments, to see their doctor, to do check ups, to know if there were any embryos to transfer and if the transfer resulted in pregnancy) coupled with the fact that the anxiety was diminished when something could have been done, shows that the productive desire is a leading force. Doyal referring to Mathieson writes, *“Waiting is the most common*

experience for infertile people. (...) waiting for the outcome of tests and waiting to see whether the treatment has worked” (1987:179, 1986:5). Though the Dutch and the Polish couples did experience waiting, and following, it anxiety, the exercise of waiting in order to commence recommended treatments was specific particularly to the Dutch couples. This is due to general medical policies in combination with internal arrangements within particular medical centers (see also Chapter Three).

“What was not easy to stand was the waiting, the inability to do something. We were on the waiting list to do AI for one year. Then we were on the waiting list to do IVF for nine months.” [Mia]

“The most difficult part was the waiting. We needed to wait about nine months. When I finally could start to inject myself, I finally started to feel good.” [Mari]

“What was hard was this endless waiting, waiting, waiting, and still more waiting and more waiting. The waiting period was the worst because you could not do anything; you just had to wait.” [Mia]

“Waiting was the worst. Not injections, not echos, not the blood samples, not ‘taking eggs away...It was hard, two weeks waiting seemed like two years. You could not do anything when you waited.” [Tru]

“We were on the waiting list for three months. That was what was the worst.” [Bian]

“Waiting was the worst as it was about uncertainty and insecurity.” [Bo]

“To wait was the worst because you did not do anything anymore.” [Dus]

“They put us on the waiting list. Three times I was told that the programme is full. It took months and that was awful. You did not do anything.” [Ane]

Making Alliances

As I have previously presented, the *ratio* did not vanish from the couples' lives. Its presence, especially perceptible when going through IVF, is said to be physically and mentally demanding. However, desire, productive and constructing assemblages were never out of the picture. Desire, as Braidotti (2002), Grosz (1995) or Ross (2005) all argue, is inventive, forms connections, makes alliances and enhances the power of bodies. The fact that the couples looked for allies, reached out and connected with others, inevitably signalizes the presence of creative desire.

“You looked for help among your closest friends. You wanted to discuss things especially with those who have gone through the same. That helped you to go on in your struggle for a child.” [Pau]

“I talked continuously with my sister. Thanks to our ‘talking’ I could continue. She told me not to give up, but to fight.” [Mal]

“You tried to find people that could help you to go on. I had one friend that had already been to the same clinic and succeeded in becoming pregnant. Talking to her gave me strength not to step back but to constantly moved forward.” [Mon]

“You talked to people with similar problems. You did it in search for hope. Knowing that others succeeded makes you believe you would have a child one day yourself.” [Magg]

“You always looked for friends. I am very talkative and I make friends easily, I simply love people. That always helps when you struggle for something.” [Ew]

“I talked to people that were in the same situation as we were. This helped.” [Mar]

Repetitions and Coming(s) Back

As desire is a force of positive production (Grosz 1995) and in the context of the human reproduction a child stands for the object of desire, the fact that the couples were repeating the procedure and/or coming back to medical centers as wanting another child, illustrates that productive desires do *“play as important and constructive role in subjectivity as rational judgement”* (Braidotti 2002:160).

“After we started, we did not want to stop. I did one IVF-ICSI after another. I would have done them till I was successful, till I had a child.” [Pau]

“Sometimes I was afraid for my health. I thought about it but not that often. I was repeating one IVF after another. It all took five years, I did not have enough. To go on was the only chance for eventual pregnancy.” [Mal]

“Wanting a child you go against the odds. You fight till the end, till you are successful.” [Viol]

“To have one child was great. However, being an only child myself, it was my dream to have another one. So we started everything from the beginning. Nothing mattered. I did not care what price I had to pay. I knew I put my health at risk. Yet what really mattered was to have another child so we went on.” [Magg]

“When we did not succeed, we started again. One child was a miracle for us, thus when our boy was one year old, I went to my doctor and said that I wanted another child.” [Bo]

Choosing Clinic(s)?³¹

It may seem that I am repeating myself, yet the productivity of the couples' desire can be mapped out and traced in many of their actions. The very fact that the Polish couples commenced their participation in IVF technique in clinics while possessing little knowledge about them, definitively shows that the productive desires matter as much as judgements based on rational argumentation.

“We did not know what the clinic was all about. I found an advertisement in a newspaper. But the clinic was the only place we could do something about our problem.” [Mag]

“We found information about the clinic in a newspaper. We had no idea if they were good or not. They were close and not that expensive. For us to go there was a chance to get pregnant and so we did.” [Ter]

“I had no idea about the quality of the treatment offered by the clinic. I talked with my friends that had already been there. Not knowing much, we still went there as it was a possibility for having a child of our own.” [Pau]

“We heard about this clinic by accident. We had no idea if we could succeed there, yet we saw it as a chance for a pregnancy that must be taken.” [Mal]

“We knew nothing about the clinic. My friend, who was there, advised it to me. I trusted her, thus we went there.” [Mon]

“I was in a hospital doing fertility tests when one of the women told me about the clinic. We did not know anything about it. We could not have checked anything. We went there because there was a possibility for pregnancy.” [Viol]

“I found information about the clinic in a women's magazine. I phoned there to make an appointment but we had no idea about their quality. We did not know if it was worth going there.” [Ewsi]

³¹ I refer only to the Polish situation as the limited knowledge about medical centers where the IVF was offered was never a case as far as the Dutch couples are concerned.

Money Matter(s)³²

The importance of the productive and inventive desire over the *ratio* is also perceptible when the lack of money did not stop couples as they tried to find ways to overcome their financial problems in order to go on with IVF technique. In Poland, human in vitro fertilization is not reimbursed and must be paid by its participants (see also Chapter Three). There was almost no single case where money did constitute a problem. When there are bills, it is as Lesley Doyal (1987:176) points out, “(...) *the possibility of benefiting from the new technologies is almost entirely determined by the ability to pay*”. Yet there was no single case when something was tried to be done about it.

“Everything was very expensive. Eventually, there was a moment when we had enough money to start the procedure, and just before I had a visit, there was an increase in the prices. So we needed to raise more money. In total, we collected money for two years to be able to commence IVF.” [Justy]

“It was expensive but we had to go on no matter what. Therefore, we had ‘IVF for the poor’ [term invented by the interviewed woman] which meant that for ovarian stimulation I took tablets instead of injections, which were more expensive. It was less efficient, but cheaper.” [Pau]

“IVF in Poland is very expensive, but this cannot stop you. You have to find ways to overcome that. We were going non-stop to a doctor asking for discounts and looking for possibilities of diminishing the costs. As a result, for example, I was stimulated with tablets. It was less expensive, though less efficient than injections.” [Ew]

Hostility³³

The importance and crucial role of productive desire as well as the judgements can be seen when the hostile attitude of Polish society was never considered as something that would stop couples from proceeding with IVF technique.

³² I concentrated exclusively on the Polish situation as the Dutch couples had their tries financially covered by insurance companies.

³³ I only focus on the Polish situation as the interviewed Dutch couples did not observe or experience the kind of hostility the Polish couples did.

“We knew that in Poland there is little acceptance of IVF, yet wanting a child we did it but not mention it to anyone but our parents.” [Ter]

“People in Poland, in general, see those who go for IVF as ‘the rich with a whim’. We did not want to be defined in such a way. Of course we did IVF, but no one knew except our closest friends.” [Pau]

“In Poland IVF is a taboo, a ‘whim.’ People understand nothing. We kept everything to ourselves.” [Bea]

“We wanted a child so we were constant guests at the clinic, yet we were always looking around to see if any of our friends were there. We knew that some had problems, but we did not want them to know that we had such problem, too. In Poland IVF is not something the general public is in favor of.” [Mon]

“We knew that IVF is rejected by the Church and that people do not accept this method of getting pregnant. Thus no one knew, only our parents and friends that have done the same.” [Mon]

“In Poland public opinion remains under the influence of religion and does not tolerate those who are ‘different.’ This could not have stopped me from doing IVF to become pregnant, but I remained silent.” [Magg]

“In Poland people are ‘anti-IVF.’ We did it but only my mom, mother-in-law, sister, and my closest friend knew what we were doing.” [Ali]

“Public opinion in Poland remains under the Catholic Church influence. People think that it is a ‘sin’ to do IVF. You do it, we did it, but no one knew and still does not know, even our parents.” [Ewsi]

Doctors and Medical Personnel

The presence of the productive desire and desiring-production next to the ‘rational-like-judgement’ can also be tracked when the IVF technique was pursued even if the access to the doctors was impaired and the behavior of the medical personnel and/or its performance not always positively evaluated.

“We were going through IVF and that was fine, yet we did not like the fact that there was no ‘soul’ there. People needed attention but there was none. Big crowds, a constant rush, and sometimes very ‘cold’ doctors. A situation one morning: two women before me, then it was my turn, got anaesthesia, they woke me up, in a second

I was in the corridor and going home. There was no support; we were completely on our own.” [Mon]

”You go on because you want to have a child. It is simple. Yet, it was so ‘cold.’ There was no support from the doctors’ side. They gave you information in a very formal way. If you had questions, they sent you to someone else and you were alone. The more I asked, the more they wanted to get rid of me. Yet, this could not stop you.” [Magg]

”I went to check if I was pregnant. They only gave me a paper with negative result. No one said anything. I could not walk. That time I desperately needed their support but there was nothing like that. Yet, we came back to continue. We wanted a child so much.” [Magg]

”The doctors were always busy. My first embryo transfer was done in a complete rush. You swallowed that and moved on for the sake of a child.” [Ew]

”The doctors never had time. You were not treated personally. That was heavy as you wanted more attention. But you could survive that.” [Ewsi]

”We hardly ever saw my gynecologist and even when we did, he never had enough time for us to discuss issues and we really needed that. It was hard that they usually showed no emotions. The occasional nurse would say “good luck with everything.” It was important to be asked how it was going, how it felt, how you were coping. During the embryo transfer no one said “congratulations.” That was not easy but sure, you go on.” [Mia]

”Misunderstandings sometimes happened. It was hard to stand that sometimes they really seemed not to care at all. Yet, I could handle it. I was trying to be realistic about it and went on.” [Mari]

”It was really difficult that every time you came you saw someone else.” [Bian]

”The difficulty was that you saw different doctors. I did not like that. They sometimes should have thought more personally. They sometimes should have thought more about the emotions of the people that were going through the process. No empathy. No compassion.” [Fos]

”Different doctors, different opinions. You were lying there, already not feeling bright and happy. Every time you had to explain as they did not have a clue because the file was not up to date. I was stressed as it was not really well organized. “Next-

You're done-Bye." You wanted to know that they cared, that they did it all the best way possible." [Dus]

Despair and Persistence

Desiring-machines “run when they do not function properly” and this is precisely what distinguishes them from “technical social machines” (Deleuze 1983). The “technical social machines” “wear out after transmitting the value to the product” (Deleuze and Guattari 1983: 31). In contrary to them, to repeat it once more, the desiring-machines (that is the human subjects) “run only when they are not functioning properly: the product is always an offshoot of production, implanting itself upon it like a graft, and at the same time the parts of the machine are the fuel that makes it run” (Deleuze and Guattari 1983:31). There were moments when the couples experienced despair and depression as the pregnancy could not be established or a miscarriage occurred. However, what usually followed was the continuation of the procedure. Thus, I would like to establish a connection and map a resemblance between their experiences and the desiring mechanism described by Deleuze. I want to show that the couples’ despair and depression can be seen as the “offshoot of production” when the desiring-machines (that is the human subjects) do not ‘function properly’ as the desiring-production does not result in the pregnancy. Yet, the product (that is despair but also the lack of the pregnancy) “implant themselves upon it [machine that is the human subject] like a graft at the same time becoming a part of the machine”. As the parts of the machine are the fuel that makes it run, all the couples continued with the procedure. Having this resemblance established, I can again conclude that the human subjects stand for the desiring-machines where desires are as important as *cogito* and *ratio*.

“Every time I was not successful in getting pregnant, I dropped and mourned. Then I stood up even stronger than before, ready to go on.” [Pau]

“You get very down, you cannot move. Each time there were no pregnancy, no pregnancy, no pregnancy, I felt I was going down and down. I asked myself whether I was not too old. Later we went to a doctor, waited one or two months and repeated everything again. We wanted to have a child.” [Magg]

“We were shocked that it did not work out at the first time. There was lots of crying and depressive thoughts. We felt desperate; we wondered what we should have done. After some time, we started everything from the beginning.” [Ali]

“When it turned out there is no pregnancy I dropped; I cried; I was in despair. But we did not wait. We wanted to fight again. We started again.” [Viol]

“We went to the clinic to check if we were pregnant. The ultrasound result was negative. I did not cry. I did not analyze it. All my joy was gone. We did not wait, we started again.” [Ewsi]

“We were very excited. When it did not work out the first time we got a bit depressed, soon after we started again.” [Bian]

“When after the first IVF there was no pregnancy, I was depressed. We wanted to have a break. But we wanted to have children and so we were back.” [Fos]

“We were feeling very disappointed when it did not work. But we continued.” [Tru]

Leaving IVF

According to Deleuze, desires are linked to the “conditions of objective existence”. When those conditions change so does desire that ‘does not live longer’ than the conditions do. Thus when those conditions change, they may simply cause “*the desire to die*” (Deleuze 1983). There were moments when some of the couples who already had had a child due to IVF technique and went for another IVF try or tries in order to have more children, eventually decided to stop their participation in the procedure. This, I want to argue, was because with the birth of a child “conditions of objective existence” got changed, and at the same time, new ones appeared (the need to bring up a child, the age, willing to live life without fear and depression or concern for one’s health) that caused “one particular desire to die”. The ‘death of the couples’ peculiar desire’, I want to emphasize, can be taken as a proof that the humans are definitely desire fueled subjects.

“We were trying to have a second child but it did not seem to want to work this time. Having one child, we decided it was enough and eventually decided to give up.”
[Ter]

“I have one child after doing IVF. I wanted to have another one. We tried but it did not work. We stopped for one reason. I realized that I had a child and that I wanted to see it growing up and be totally present in this process.” [Mal]

“I have one child thanks to IVF. It would be fantastic to have another one. However, having already one child I did not want to feel all those fears again and to go for and through all those depressions again.” [Bea]

“I would like to have another child. Yet I have one and I am almost forty, thus I do not think I will try it again.” [Mari]

“I have one child after IVF and I am very happy with that. I would like to have another child but I do not feel like doing the IVF. With our child, we succeeded the first time but we know that might not be the case if we try again.” [Brink]

“Having two children, we do not think about IVF anymore. We stopped after that.” [Mar]

“I have one child. I would like to have another. But I have one child already and I want to live for it. I want to stop. I am very sure about it. It is not good for me or my mental and physical health.” [Jus]

“We do not want to do IVF again. What for? We have our miracles and we are happy. What also stops me is my age. I am about forty years old.” [Bo]

“I asked would I be happier with three, four, five children. I love children but the happiness that I feel with this child is not going to increase with the second child. This is enough. This is the best thing that happened to me. I would like to have a second child? For who? (...) We are forty-four taking risks for what? [Ane]

The Subject: Desire versus “Rational Judgement”

The Importance for the IVF Debate

When desire’s importance and “constructive role in subjectivity” is recognized, then it becomes possible to produce more accurate but also more positive evaluation of human in vitro fertilization. More accurate as it allows recognizing and defining processes responsible for the subject’s actions. With the realization that desires are as crucial as “rational judgement”, it can be acknowledged that the one does not necessarily exclude the other. As I have presented, the couples frequently point out that participation in the IVF technique/practice can be mentally (the necessity to “lay bare sexual selves”) and physically (pain accompanying certain practices)

demanding. Yet despite all that, the couples continued their participation in it. Similarly, there were couples that had already experienced the first IVF try and so knew what they could continue to expect throughout the whole procedure. Therefore, the radical feminists' conclusions that those who go through IVF technique/practice must certainly be brainwashed marionettes with no sense of what they do and no control over their bodies, reproduction and that therefore their new conceptive techniques/practices are abusive, do not seem to be correct. At the same time, when the constructive role of the productive desires in subjectivity gets recognized, all the performed actions and activities (doing IVF, repeating IVF and coming back to clinics) can be seen as equal to the productivity of desire. Desire and the desiring-production are all about positivity, multitude and joy (all the couples felt good while doing this). The possibilities of acting/doing were a source of good feelings, whereas the need to wait or to postpone production resulted in the anxieties and disturbances. In this sense, I can contend that even if the IVF technique/practice can be mentally and physically demanding, it can also generate positive emotions, empowerment and the sense of being in control. Furthermore, recognizing the importance of desire, I can argue that participation in IVF technique/practice, being a desiring-production, is not sustained and continued by doctors or any medical powers but by the very nature of the desiring-machines. Furthermore, as the productivity of desire (doing/repeating/continuing IVF) stands for the "integral process of desire" and takes place on the "desire's plane of immanence", IVF technique/practice cannot be evaluated in terms of the abuse. Desire is not taken out of this 'plane', thus again, it does not lack but produces. Therefore, desire that is production (doing/repeating/continuing IVF) and the object of desire (a child) do exist/happen on the same plane of immanence. As such, IVF technique/practice being situated on the "side of production", not acquisition, cannot be evaluated as an abusive technology/practice. While the radical feminists rely on the negative argument that says that IVF simply cannot 'promise a fulfillment of desire' (i.e. give the couple a child) it is, in fact, not a 'promise of a fulfillment' (with the promise being associated with possible lack/unfulfillment) but it is that very 'fulfillment' itself.

Certainly one can say that IVF clinics and the method/practice itself have controlling functions (can enhance the controlling powers of doctors) and are thus abusive which

would confirm the radical feminists' and the Vatican's positions. Yet when based on a Deleuzian concept of desire, such supposition can be changed. For Deleuze, social production is always already the desiring-production (Deleuze 1983). It is because, as Colebrook explains, "*Social wholes take desires-or those connections which enhance life-in order to produce interests- 'coded,' regular, collective and organised forms of desire*" (Colebrook 2002:91). Thus desires are never out of the picture yet they are usually enclosed within coded blocks/images. For Deleuze, as Colebrook argues, "*the problem of usual explanation of social powers (...) that it begins with interests (...)*" (Colebrook 2002:92). Thus, I would say one should not be fooled by the coded and organized forms of desire (the promise of a child) but one should go to the core of desire: that it is "*the concrete and specific connection of bodies*" (Colebrook 2002:92). When desire and the desiring-production are recognized, IVF technique/practice can be seen as the desiring-production, the connection of bodies expanding/enhancing their power, and so, far from being controlling and abusive. Yet, one may say that IVF technique/practice still can be assessed as abusive because the bodies that get enhanced can also be those of the doctors. With such a suggestion I must agree that even if doctors do expand their power, at least they can be counter balanced by the equally enhanced bodies of their patients. Furthermore, with desire, defined as crucial for subjectivity, linked to the "conditions of objective existence" and so prone to extinction (some couples terminated their participation in IVF) it cannot be said that new reproductive technologies are abusive and irresistible. The radical feminists, but also the Vatican, have emphasized many times that IVF technique can be demanding and negatively affect the person on different levels (Donum Viate 1987). Certainly depression, despair, anxiety and fears of different types can be experienced and felt. However, with the acknowledgement that the human subject stands for the desiring-machine, it appears that depression or despair is not the direct outcome of IVF technique. What is more, if it is known that productive desires are important in subjectivity, then it is rather obvious that the moments of waiting (for embryo transfer; for the results of pregnancy tests) that slow down the productivity of desire do result in experiencing anxiety. Therefore, it can again be said that it is not the technology itself that is solely responsible for the depression and anxieties, but rather the very 'nature' of desiring-machines. I am aware that such a statement for many can sound too vague or detached from reality.

Yet, when IVF technique is internalized (productivity of desire) the anxieties or depression can in fact simply be products of the internal production for which the desiring-machines are responsible. Furthermore, when the constructive role of desire in the human subjectivity is recognized, and as such the participation in IVF technique is seen as the desiring-production, it seems to me that fears, which can be experienced during it, remain external to the desiring-production. I see the fears (usually that *“nothing will finally work”*) as rather originating from the “rational judgement[s]”.

“Going through IVF, I was so scared wondering if it was not too late, if I still had time, if I could manage before there were no more chances and nothing would work.” [Pau]

“I was constantly feeling fears. We were thinking that maybe we were too old for all this.” [Magg]

“Sometimes I got really scared. I realized that it did not matter how many IVFs we would undergo. It could be that I might never become pregnant. I got even more scared realizing that I was getting older every day.” [Ewsi]

“Insecurity was the worst part. Stimulation did not go well so we were scared if it all could result in pregnancy. There were moments when you started thinking if all that you were doing was worth it, all the examinations and treatments. You started thinking that maybe you should accept the fact of not being able to have children and go on with your life.” [Mar]

“We had fears that it was not going to work, that it would not work out for us.” [Bian]

“You are very scared when they give them [embryos] back. You are afraid that they will not settle. I was laying down so I wouldn’t lose them.” [Fos]

“In the back of my mind I had, of course fear: What if this did not work, what would happen? Then you think about it and ‘ooh’ I would totally collapse.” [Dus]

The recognition that desires matter as much as “rational judgement[s]” and play important roles in subjectivity, allows the proposition of more accurate approach towards in vitro. If, the important role of the productive, positive, creating assemblages, forming connections and enhancing the power of bodies desire gets

realized, then the whole procedure does not seem to be abusive in the way the radical feminists and the Vatican see it. What is more, with the realization that “rational judgement” and productive desire both matter, then it is obvious that the desiring-production will always strive to be initiated, continued and maintained. Therefore, instead of the non-approval of IVF, it would be better to ensure that the productivity of desire is an optimal one.

With desire seen as intrinsic to the human subject (next to the “rational judgement”), IVF does not have to be conceptualized as abusive technique/practice that ‘rips the control over reproduction off couples’ hands’. IVF technique/practice demanding as it can be, may not necessarily be defined as a method that stands for a source of depression, anxieties and fear, thus again abuse. On the contrary, IVF technology can be perceived as generating positive emotions and empowering production.

IVF as a Procedure Where a Man is Present

The Importance for the IVF Debate

To recognize that IVF is a procedure where a man is present, is to recognize that a man may also become a target of the social expectations (i.e. to enter fatherhood) and critique if unable to fulfil his ‘duties’ (Zipper and Sevenhuijsen 1987; Hardy and Makuch 2001). To acknowledge a male presence is also to see that the feelings of the embarrassment and ‘uneasiness’ when not meeting social expectations and not being ‘fit’ enough are not alien to a man (Hardy and Makuch 2001). A male presence also allows realization that a child does not only constitute the female’s object of desire. Mag said, *“It is not true that only women want to have a child. Men also want it.”* Furthermore, the recognition of a man’s presence, is the recognition of his becoming a patient, an object of examinations, an active participant (in traveling through doctors’ offices and gathering money) and the IVF clinic’s inmate involved and embraced by the medical machinery. Lastly, the realization of a man’s presence allows seeing him as the one who may have fertility problems and, more importantly, as the one who can be fully responsible for a childless situation of a couple.

Such realization(s) are then essential for a more accurate and, in fact, more positive assessment of IVF technique/practice. This is because it permits the conclusion that a

man becomes involved in the whole reproductive machinery and is affected by it. In this sense, I can say that new conceptive techniques do not target or have impact solely on women and, on this basis, they cannot be simply seen as abusive (what the radical feminists did). With this I am not trying to say that the physical burden is the same for a woman as for a man because it is not. What I am trying to make clear is that assisted technologies do not remain neutral towards men. On the contrary, they address him directly and invite him for full participation.

With this realization a more accurate approach can also be proposed. I said that the recognition that a man is present in the 'reproductive matrix' is the recognition of a man experiencing fertility problems. Therefore, not non-approval of IVF but rather the creation of an environment where men can face and solve their fertility problems more easily, appears to be a more proper approach towards human in vitro fertilization.

Again, by no means I am trying to argue that it is not a woman, a female body that plays the major role in assisted reproduction and going through all the tests, examinations and various types of treatments. However, with a male presence recognized, the concept of IVF technique as targeting only woman and focusing only on female reproductive capabilities has chances for a positive transformation.

In Vitro as a Part of a Longer Procedure

The Importance for the IVF Debate

In vitro is not disconnected and does not exist in time as a 'singular' phenomenon. In vitro is always embedded in a bigger context. Firstly, the couples realized that 'natural' conception did not take place for a relatively long period of time. Secondly, the various examinations and tests were undergone. Thirdly, different kinds of the treatments such as laparoscopy or artificial inseminations were performed. Fourthly, some couple were sent home to try to get pregnant in a 'natural' way. Fifthly, IVF technique was eventually suggested. If IVF technique/practice is seen as an element of a longer procedure, its better evaluation can certainly be provided. Being perceived in this manner, it appears that IVF technique is not always offered and certainly not immediately to everyone that opens the door to an infertility clinic (see

also Chapter Three). As this is what the radical feminists have indicated, and on such basis have evaluated IVF technique as abusive, it does not seem they were right in their conclusion. Furthermore, with in vitro perceived in such a manner couples' participation in it gets a different meaning. Seen as an element of a longer procedure, IVF technique appears to be one of many tried and checked options. Therefore, couples' participation is not an effect of being brainwashed and proof of them becoming marionettes in the doctors' hands. On the contrary, to go for IVF technique is to try another option and to make the optimal decision. Therefore, the abusive nature of IVF technique built from the radical feminists' ideas of people being brainwashed and passive does not seem to be valid. Thus, a non-approval of technologies does not appear to be a correct approach either. In this sense, the concept of IVF technique as abusive once again can undergo re-definition to be eventually conceptualized as the optimal choice made under certain circumstances.

PART II

Suggestions and Recommendations

'No body' can easily skip the 'radiation' of the social and symbolic forces. Thus, the human subject 'naturally' becomes the "play" of those forces. The mentioned forces influence the actions and participate in the production of the subject's certain thoughts and emotions. In the realm of human reproduction, those forces like to indicate the necessity of pregnancy or make one to feel 'uneasy' when not meeting the loudly articulated expectations. In vitro in many medical centers does not lure, does not force people to make children, does not strengthen notions of motherhood and does not want to prove one's 'fitness' by the very fact of its existence. Not to approve IVF will not do much good to anyone, but to create a wall between IVF and socius, so the latter will not fuel the first, certainly will. The human subject wants to know. It feels good when life is clear, transparent and understandable and so it strives for the desired transparency and clarity. The women and men want to know why they cannot conceive in a 'natural' way. The IVF clinics, doctors, examinations and diagnosis bulldoze through shadows and ambiguities. The human subject is fueled by desire; thus the subject acts, does, moves, connects, links, creates, invents and so 'stands' in the 'mode' of constant production. The infertile couples talk with those experiencing similar situations, they ask questions and search for the answers.

The subject does not favor the stoppage or any type of petrification. Thus it is anxious when the blockages appear, when it is difficult to explain and when it needs to wait too long for understanding. The IVF clinics, doctors, examinations, IVF technique and practice enable the 'rush' and become the subject's 'rush' and the production themselves. They are not alluring but empowering. The life changes, it flows and so does the human subject. The life is a process and so is the subject itself, in love with flows, transformations and metamorphoses. The subject never stays the same. It is not familiar with the *constans* in the mathematical sense as it constantly becomes while shifting and meandering, negotiating the possibilities of the desired, but not always allowed, re-arrangements of the life's river-bed. The subject negotiates, and as simply as that, it sometimes does what it wants and sometimes it does not. It all depends on what is at stake and on the possibilities of acting in a certain way. The decision to go or not for tests and IVF itself is always the outcome of negotiations. Many factors participate in the process of making decisions. Many things do matter. The decision depends on the subject's encounters, on its beliefs, fears and dreams. IVF does not always have to be chosen, it is not alluring, it does not take the reproductive control away from women and it does not turn women into victims. It can be the last chance but the 'lastness' of this chance is born at the crossroads of desire and various powers where one overbalances the other. The idea of life without a child, one's partner, age, the impossibility of getting 'naturally' pregnant or the possibility of having a chance. The subject is in love with the productive desire that *nomen omen* is productive so the subjects acts, does and creates in a very productive mode with the object of desire implanted in every action and production. The desire matters as much as does the "rational judgment". The physical pain does not have to take control when the desiring-production takes place. The difficulties as the lack of money, the hostility of others or unprofessional actions can be overcome with the creative desire, the joy and excitement can be experienced when the subject is in the production mode. Anxiety and despair can be felt when the production is blocked and the production can be transformed into another one when one has enough or loses interest in the possibly produced product. The human subject is a desiring-machine that produces and enjoys but also experiences anxieties and sadness precisely because it is desire fueled. The 'doing' of IVF is about desiring-production and not about 'pure brainwashing'. It is about the generation of positive emotions,

about empowering and about being in control. It is about bodies connecting and enhancing their powers. Not to approve IVF will not do much good, to make the productivity of desire the most optimal one certainly will. IVF is usually not immediately recommended and it stands for one option and the optimal decision. In many cases, it becomes impossible to tell the reasons why couples cannot get pregnant. Usually, when there is no clear evidence (such as: removed fallopian tubes; lack of spermatozooids due to chemotherapy) artificial insemination is recommended. In cases with no visible evidences it is the period during which couples tried to establish pregnancy and the age of female patients taken into account when the decision about performing IVF technique is made. IVF does not target only women as it is not indifferent towards men. On the contrary, it welcomes them. The procedure leading to IVF and the IVF method itself require the presence of both female and male bodies. Various tests, examinations and treatments performed in order to map out the causes of problems with conception or solve them, are not only performed on the female bodies. New reproductive technologies attach male bodies to the practice of 'production' as well as to reproduction. Male genitals also become reproductive ones, and in many cases, they turn out to be dysfunctional, in demand of technological mediation. He becomes a patient, he undergoes evaluations and assessments and he may be the reason for which there are no children in the landscape. A man is a target of social expectations; he can be criticized and laughed at when childless for too long. A man may feel 'uneasy' and desire to have children. Not to approve IVF will not help, to create the environment where both women and men can face and solve their fertility problems will.

In Poland, the position of the Vatican on human sexuality, reproduction and assisted conception has significantly conditioned the situation where fertility issues have not been seriously addressed and publicly debated (see also Chapter Three). Consequently, as not discussed, the phenomenon of infertility remains linked to human sexuality, approached as shameful and private. Thus, infertility is also perceived as shameful and private. Furthermore, as fertility problems have not been subjects of public debate certain beliefs and societal reactions concerning reproduction have not had chances for positive transformations. Therefore, for many Polish couples fighting for the chance to have a child, the whole experience becomes

very heavy. Feeling ashamed, remaining silent and secretive, the couples I interviewed did not share their worries and problems that resulted in the negative feelings and emotions. As I have said, it was very difficult for the Polish couples to admit that they had those kinds of problems. Such recognition was especially hard for the Polish men. Thus, it would be no surprise if some women faced problems having their male partners visit doctors' offices. The radical feminists worry that new reproductive technologies only put additional burdens on women. Surely, they have a point there. However, they do not envision that a situation in which technologies are 'asked' to be banned (Poland) can in fact put more burdens on the women's shoulders than when they are regulated and widely discussed. Of course, I do not want to put all the blame on the Vatican. Yet, its 'share' in the whole situation as it is in Poland now, cannot be denied. The call for non-approval has created situations where real abuse can happen. Because of the Vatican's position, followed by the Polish Catholic Church, IVF, infertility and the methods of handling it have not been addressed or discussed and nothing has been done about them (see also Chapter Three). With the fertility problems not discussed and the ways of overcoming them not debated/organized/formalized the infertile couples, may experience various difficulties and in addition also get exposed to real dangers. It is because such a situation allows for the proliferation of unprofessional centers, lack of or wrong advice, long journeys made by these infertile couples, repeated tests, dangerous treatments and exposure to physical and emotional risks. As possible help can be found in centers whose quality cannot be verified and are generally treated as private enterprises, couples either never get there (losing the chance for the professional help and as such time, physical and mental health), get there but still do not receive a good/constructive advice (as quality cannot be checked/verified), get there but find themselves in danger that IVF will be immediately advised, even to those who really do not need it. Greer points out the possibilities of the realization of the latter (though not in the direct references to IVF) writing that, "*Fertility specialists draw up a criteria for the evaluation of their patients, but in the face of the woman's desperate insistence these criteria often go by the board*" (Greer 1985:46). This is especially the case when, I would add, financial profits are at stake. The couples go against all odds, if needed. They do not stop but not knowing where to go and whom to trust they may experience real hardships and in this sense, abuse. As such, the call for a

ban has had its outcome in the increase of the 'possibly-already' experienced anxieties and stress caused by the fertility problems and can turn the life of the couple into a really miserable one. At the same time, because the "wilful choice" is the optimal one in the given context, it can be that it does not have to be the healthiest one. This is the case in Poland when the couples, being worried about their financial resources, but at the same wanting pregnancy, opted for the transfer of the highest possible number of embryos, risking their health, but also the health of their prospective children. The couples go on, yet with the unchecked quality of clinics and lack of resources, the personal 'costs' can be very high. It does not have to be repeated that the Vatican, has played a significant role in creating such a situation. In this sense, the call for a rejection of IVF has created the potentially abusive situations (exposure to the grave health risks and creation of surplus embryos) the radical feminists and the Vatican both worry about. In Poland, infertility and ways of overcoming it have not been discussed which has resulted in the lack of the legal arrangements and IVF technique being taken over by the private medical centers. Due to this, the quality of clinics cannot be verified, the procedure is not financially reimbursed and all costs must be covered by participants. The fact that in order to go through assisted reproduction one must pay, not only makes it difficult for the couples in terms of affordability but also in terms of 'social survival'. With the term 'social survival' I refer to the hardships generated by the social attitude that the IVF couples may have to go through. The point is, that because IVF is not made familiar to the general public and is situated in the private medical sector, and at the same time, condemned by the Vatican and the Polish Catholic Church, IVF is seen as a rather strange, alien-like, commercial and commoditifying practice (see Chapter Three). Therefore, in Poland, assisted couples are usually perceived as, as Pffefer puts it, "*(...) the sort of people who equate children with stair carpets and microwave ovens, that is items to be purchased in the market*" and as those who "*(...) place a monetary value on an experience which, for many, ought be a 'gift from providence'. Their very seeking after parenthood becomes the mark of their degradation*" (1987:97). Therefore, it has happened quite frequently that the Polish couples, as Lesley Doyal writes, did not succeed "*(...) in trying to get sympathetic help*" (1987:174). Furthermore, children conceived due to in vitro technique/practice may be approached with suspicion as the test tube, artificial and clone-like babies. It

is, to say it simply, 'not nice' for the parents or for the children to be possibly put on 'negative' display, to be made fun of or simply attacked. Because of that, to go through IVF technique and practice was really a tough experience for many Polish couples. They constantly feared that someone could find what they have done and how they and their child would then be treated. They also tried not to mention that the conception of the child had anything to do with in vitro and to erase all its traces.

"We had to be very careful not to tell anyone. We did not want to be the objects of hostility. The nurses in one hospital did not want to give me an injection when they realized that it is for IVF. It was really tough to try to keep it secret. We did not say anything. We did not want our child to be treated as a 'technological product.'"

[Justy]

"To not be attacked by others we had to keep everything to ourselves. When I opened the door to the clinic I was in 'my world'. When I closed it, I entered a 'taboo world.' Not to be able to tell, to share, to admit that we were doing IVF was really difficult."

[Ali]

"It was really hard not to be able to tell what you were doing, especially when you needed to take a day off to go to a clinic." [Ew]

"We did not want to be an object of hostility. It was so hard to always cover up that you did IVF. It was also tough because every time you went to the clinic, you needed to lie about what you were doing. I did not want people to look at my child as the 'UFO-child', 'artificial', 'artificial creation', 'something else' and more like a 'curiosity'." [Ewsi]

"We did not say a thing. We did not want our child to be seen as 'artificial'." [Ter]

[Bea] [Mal]

"I kept everything to myself. I did not want my child to be an 'object of wonder.'"

[Bea] [Ali]

"We did not mention IVF. We did not want anyone to talk about our daughter as a 'test-tube baby.'" [Viol]

"We did not talk. We did not want our child to feel discomfort in the future. We did not want others to see our child as something 'less' and as a 'test-tube baby.'" [Lid]

In the Netherlands, problems with fertility and IVF technique have been addressed and discussed and the technique has been regulated so that nowadays society is familiar with the phenomenon of infertility. IVF is thus not treated as a strange and commercial enterprise. Furthermore, parents are not afraid that their child will be referred to as artificial, or for that matter a strange creation. Thus, none of the Dutch shared the Polish couples' experiences.

"Everyone knew that we did IVF." [Mari]

"I had and have no problem talking about us going through IVF." [E1]

"We talked about it with our friends openly. Even at my work I told my boss and some colleagues. I did this because I knew every time she would have to go to the hospital, I would have to go with her. There was a full understanding. That really helps." [Tru]

"When we decided to go for IVF, we told people. It was because you needed leave work often. Thus, it was better to tell and people were very understanding." [Mar]

"I did/do not have problems talking about IVF. I did/do not feel like, but if anyone asks it is ok for me to admit that I did IVF. It is really important to have people to share with." [Bo]

"I had no problems with talking about it. It is intimate so you did not share it with everybody. I said it at work to warn people as taking hormones could have influenced my behaviour. They found it difficult for us, but everyone was very sympathetic." [Fos]

For the Polish couples, to go through IVF practice was also a hard experience because of the fears concerning the lack of the financial resources. Quite often the Polish couples were worried that they would not have enough money to go on with in vitro.

"We went through many sleepless nights worrying about money. Yet we knew we had to collect it as we had to continue the procedure to have a child. Not to be able to go on with IVF would have been worse than death." [Justy]

"The biggest fear was that there would be no more possibilities of getting the money. But it was certainly not a reason to give up at the beginning." [Pau]

“While doing IVF it was awful to think that it could happen that we would not have enough money to go on.” [Bea]

“We did not want to think: what if there were no financial resources. That would be a catastrophe.” [Mon]

“The biggest fear was that that lack of money would have equalled the lack of children. The worst was to know that there was the possibility but we could not afford it.” [Mag]

“Not to be able to go on because of the lack of money would have been the worst scenario ever. I would not be able to forgive myself till the end of my life that we did not try again because of the lack of money.” [Ali]

“I would not have been able to survive knowing that there was a possibility, but not for us.” [Viol]

And again the Dutch couples' experience was of completely different nature.

“We did not worry about finances. We had everything covered. It was really good not having to worry about money.” [Mari]

“Money did not constitute any problems. We were insured and the procedure was covered.” [El]

“We were really lucky that we our insurance covered all the costs.” [Syla]

“We did not have to worry about the money. We did not pay for anything.” [Mar]

Furthermore, in the Netherlands, couples usually know how to proceed and are most likely to end up in controlled and monitored clinics with well-trained medical professionals.

The proposed theories and manners of discussing in vitro, the more accurate and balanced evaluation of, concepts of and approaches to IVF, but also the descriptions and presentations made in this Chapter result in certain recommendations for the Vatican, the radical feminists, feminists and those involved in men's studies regarding how to 'go about' IVF technique and practice.

First of all, it is crucial to examine the socius. As Deborah Lynn Steinberg emphasizes, “*What seems more important (...) is the understanding of the complex social relations of inequality that make IVF seem an appropriate or even desirable choice for some women and not for others*” (2000). Furthermore, it would be desirable to criticize and make the ‘existence’ of the socius and its ‘nature’, especially when it comes to the issues of human reproduction, visible to the public. I am aware that this is precisely what the feminists have been doing for a long time now, yet it seems that the ‘existence’ of the socius is still like the ‘existence’ of the Matrix.³⁴ Maybe it is felt, maybe it even pinches, but the awareness of it, thus the full awaking and release from it, cannot easily happen. Therefore, even more audible critique of the socius and the increased visibility of the ‘existence’ of the socius and its nature are truly necessary. As I have already argued in Chapter Three, it is crucial to stop calling for the non-approval of human in vitro fertilization especially when the one who advocates such an idea possibly represent the influential institution (the Vatican). Instead, it is essential to advocate and assure the establishment of medical centers where fertility problems have the chance to be seriously and professionally addressed, the proper provision of information (i.e. clinics’ whereabouts, clinics’ quality, possible side effects and health risks), affordability, accessible and ‘emphatic’ medical staff, psychological and social help, support groups and ‘room’ for the patients’ voices. However, in culture(s) so preoccupied with fertility and reproduction, where “*Fecundity was the underlying principle of which productivity and creativity were the metaphors*” and where “*The rice thrown at weddings was not mere rice, nor was it the wealth the union may bring, it was the seed that would impregnate the bride*” (Greer 1985:37) it is no wonder that the rise in sterility is met with more and more advanced techniques. The challenge is on the one hand not to neglect couples’ ‘wish for a child’, and on the other, not to allow IVF technology to be the only possible solution, miracle cure or a powerful apparatus of reproductive control and obligatory heterosexuality. Certainly, IVF should not be advised to everyone, made a fantastic remedy to all problems, function on a mass scale and be uncritically admired. What I am trying to say is that the desiring machines produce and as such, it is better to have this production located in the most hospitable settings. Thus, it is also important to turn IVF into a controlled and monitored

³⁴ The Matrix understood as a constructed reality of which artificiality the citizens are not aware. This definition of the Matrix is based on the movie The Matrix (1999) by Andy and Larry Wachowski.

practice yet keep the content of issued laws and those who write them under close scrutiny (see also Chapter Three). It also remains crucial to supervise the trajectory that eventually leads to the decision of performing IVF technique, to examine and investigate the necessity and reliability of the recommended and performed tests and examinations which are later on used in the decision making processes. Feminists should also make efforts to eventually establish the best parameters on which to base choices of applying the IVF method. The assurance that IVF technique is performed only when it is truly needed, and not the rejection of the method, will allow respect for couples' wishes and desires. At the same time, this will prevent the IVF method from being turned into an apparatus of reproductive control. Furthermore, efforts should be made to explain human in vitro to the wider public, to make it understandable and known phenomenon (see also Chapter Three). Yet, the way it is represented must constantly be under scrutiny. Not as miracles on display but the twenty-five percent chance of success, the pain, anger and sadness that go together with the enormous joy and empowerment of IVF participants. In addition, the concepts of 'sexuality-fertility-infertility-IVF' should leave the ambiguity of the 'grey zone' and become widely discussed and known phenomena. Thus, the efforts (i.e. advocating for more informative programmes including male problems with fertility (the task for feminists and those dealing with men's studies), abandoning certain argumentations regarding sexuality (the task for the Vatican)) should be made to have hopefully such state of affairs.

The proposed theories and manners of discussing in vitro, the more accurate and balanced evaluation of, concepts of and approaches to IVF but also the descriptions and presentations made in this Chapter result in important suggestions regarding theory of desire, feminist theory and men's studies theory.

"Feminist theory has produced an impressive corpus of texts on the imaging of the female body in the arts, photography, cinema, and the media" (Shohat 1998:240). Anyone that is familiar with feminist studies and feminist critique is well acquainted with a long list of publications emphasizing how the female body, throughout the centuries, has been constructed and conceptualized as first and foremost reproductive and maternal in contrast to the male body as 'productive' (Jordanova 1989; Moore

and Clark 1995; Greer 1985). *“Bodies are heterogeneously constructed by individuals and collectives situated differently in terms of time, space, and commitments of many kinds”* (Moore and Clarke 257). The role the medical field, especially anatomy, has played in defining the female body as being all about reproduction has been widely commented upon. *“Anatomical explanations of the female body which insist on the genitals as reproductive, regardless of whether they are also viewed as sexual, serve as yet another way to discipline and naturalize women both in a Foucauldian sense and in terms of the performative elements of female gender as defined by reproductive capacity”* (Moore and Clark 1995:292). Female genitals have been discussed, narrated and represented as reproductive in order to enclose female sexuality in a ‘reproductive box’, make it latent, passive and subordinated, and so to justify her social role as a docile mother attached to the domestic sphere and to assure male control over women (Tuana 2004; Moore and Clarke 1995; Friedman, Weinberg, Pines 1998). Nancy Tuana stresses, *“(…) the typical evolutionary accounts of female sexuality explain all basic aspects of sexuality in terms of reproduction. It is rare to find an account in which sexuality is treated as an autonomous set of functions and activities only partially explained in terms of reproductive functions”* (2004:219). She also emphasizes that *“The desire to make the human female orgasm unique was linked to the desire to argue for the so-called “pair-bond,” that is, monogamous heterosexual coupling – the family values script”* (Tuana 2004:222). In a similar vein, Moore and Clark point out that in the 1970’s human sexuality was discussed by anatomists *“(…) in heterosexual terms, limited to penis-vagina intercourse, and inherently linked to reproductive function”* (1995:275). The reason that female sexuality has been reduced to reproduction, according to some feminists, has to do with *“(…) the fear of female sexuality (…) and men’s basic envy of women’s ability to give birth. Through reaction formation this envy is transformed to a basic disregard for women and constant attempts to limit her sexuality and direct into motherhood. As long as a women’s sexuality remains in the family sphere and is channeled to procreation, it receives full legitimacy. When her sexuality is ‘uncontrolled’ it is seen as illegitimate and is criticized and penalized”* (Horney 1967 in Friedman, Weinberg, Pines 1998:783). As a result, the female body, female sexuality and female social roles have been set and organized around her ability to carry the pregnancy to terms and to give birth. As a

result, womanhood, as Linda McDowell stresses, appears to be about “*self-sacrifice, submerged sexuality, family duty and motherhood (...)*” (2003:23). The moment feminists’ texts have pointed out the structured ‘nature’ of female identities, motherhood has started to carry the mark of an obligatory/compulsory status assigned to every woman. Consequently, I want to suggest, the notion and practice of motherhood has become charged with negativity possibly signifying patriarchal dominance, control and oppression, or as Greer puts it, “*(...) a deeply disadvantaged and conflict-ridden condition*” (Greer 1985:45). Though the feminists’ texts have emphasized how female bodies became contested ‘spaces’ and how female sexuality got channeled and enclosed, the female body and sexuality are still seen as serving one goal: that of reproduction. Thus the pressure on women to deliver children continues. Friedman, Weinberg, and Pines emphasize that even if there are many changes in “*perceptions, attitudes and behaviors associated with both motherhood and female sexuality*” still those “*(...) views are not necessarily followed by deeply rooted inner and even unconscious attitudes and perceptions*” (1998:799). The general cultural imagery of female bodies, sexualities and femininity, especially when constantly fueled by present day intertwined medical, scientific and popular practices and discourses, does not seem to be prone to change or transformation (Hartouni 1998; Shohat 1998; Stabile 1998). Yet, certain conceptualizations and theories which appear in feminist writing can divorce the female body and sexuality from the practice of reproduction, which are still married in the mind of an average citizen. They can also show the average citizen that to be a woman does not have to mean reproducing and being a mother. To detach the female body and sexuality from reproduction does not mean to theorize it as not enjoying its reproductive capabilities. It also does not mean to write about it in a way that denies its materiality and the specificity of female embodiment (French feminism (Kristeva, Irigaray, Cixous); corporeal feminism (Bordo, Grosz); feminist theories of sexual difference (Braidotti, Irigaray). The materiality of the female body and the specificity of female embodiment must be appreciated without the direct and ‘iron-like’ link leading straight to the practices of reproduction. With woman seen as a “*complex and multilayered [yet]*³⁵ *embodied subject*” (Braidotti 2002:170), with “*differences among women*” (Braidotti 2002: 170) acknowledged, with subjectivity seen as a

³⁵ Emphasis added

“process” and as a “becoming” (Braidotti 1994, 2002) the female body, though able to give birth can also be conceptualized as indulging in a myriad of practices, not only reproduction. Female sexuality may follow precisely the same way and go in the direction of redefinition and release from the shackles of reproduction. The proposed theories and manners of discussing in vitro, the more accurate and balanced evaluation of, concepts of and approaches to IVF in addition to the descriptions and presentations made in this Chapter enable the emergence of the theory that says that with IVF technique and practice (which is available to all sorts of people: heterosexual, lesbian and gay couples, as well as, people without intimate partners) (1) the female body is freed from associations with the obligatory practice of reproduction (2) ‘every’ female body can no longer be freely associated with reproductive practices (3) reproduction is no longer an exclusively heterosexual activity and particular female obligation. The manners/evaluation, concepts/approaches/description also allow creation of theory that emphasizes that it is for the first time that the medical field has given to the feminists a ‘weapon’ (IVF) to use to argue against everything the medical field has done to the female body and female sexuality. They enable theory that points out that with IVF (which extensively focuses on activities intended to solve conceptive problems) female bodies can be seen and known as sexually active. Even if IVF has to do with reproduction, this time it is not reproduction hiding sexual activity but reproduction putting sexual activity in the spotlight. Rey Chow stresses that, *“In Freud’s account, human sexuality is not essentially oriented towards reproduction, yet human society systematically channels it in such a manner as to make reproduction the ‘happy ending-ideally, in the form of the woman’s birth of a male child in heterosexual marriage”* (2003:318). Yet, the proposed theories and manners, concepts and approaches, descriptions and presentations allow theory that stresses that with IVF (where sex becomes divorced from reproduction) female sexuality is free to become anything it wants to. To divorce the notion of a woman from the notion of a mother is not to say that a woman may not become a mother, or to disempower/devalue women, but to problematize and ‘positively charge’ the notion of motherhood. The practice and so concept of motherhood appears to be equal with the social/cultural presumptions that every female should not only have and nurture a child, but also want to have and to nurture a child due to a biological urge or ‘natural’ instinct. To ‘positively charge’

the notion and practice of motherhood is to reconceptualize it in such a way that will not allow viewing motherhood as the female's destiny and obligation, the only state/practice she can be identified with, the only female desire that is 'natural' and not social and cultural mediation. The proposed theories and manners, concepts and approaches, descriptions and presentations make it possible to come up with the theory that stresses that with IVF (which enable not only heterosexual couples to have a child) motherhood stands for a possibility, one of the options that is 'destiny-and-obligation free' and can be chosen from many other available. Motherhood is not grounded in female biology but is a chosen-actualized option, a possibility. It is not a destiny and desire particular and intrinsic only to female subjects. Theory that emphasizes that with IVF (which explicitly indicates that not every woman can get pregnant and give birth just because she has a female body and recognizes that female organs, though defined by biology as reproductive, are not or cannot be reproductive in every case) motherhood is not a destiny but rather a possibility. Rey Chow, in her comments on Freud's theories points out that, "*Reproduction (...) belongs in Freud's story on the side of the social imperative, as part of that coercive script that human being, especially women, have to mimic and learn to 'want' for themselves. Taken radically, Freud's theory implies that biological reproduction, especially in the case of women, can in fact be seen as the ultimate source of social oppression*" (2003:318). Yet, the whole discussion in Part I of this Chapter makes it possible to come up with the theory that points out that with IVF (which is frequently repeated, demands various examinations, interventions, sacrifices and struggles) motherhood is about desiring-production and is not a destiny or obligation. Motherhood is not the only identity a woman can reach but it is a phenomenon fueled by a productive, joyful, creative and power-enhancing desire. Motherhood is a positive and affective state that has much less to do with destiny, obligation and imposed identity and much more to do with joy, passion and excitement.

Speaking of desire, the discussion in Part I also allows for coming up with a positive theory of desire. Behind the most important and known theory of desire undoubtedly stands Sigmund Freud. Although, his theory definitively gives some understanding and explains some particular reasons for the human subject's actions, it is very negative. His notion of desire has to do with aggression and violence; it targets the

object as to 'consume' it thus from the moral perspective desire cannot be evaluated positively. It includes primarily negative emotions. The moment of rapid and violent consumption and fulfillment is a moment of emptiness, of no desire left. Thus conceptually, desire is linked with entropy as it aims at its own exhaustion and it 'zeroes' itself out. I have already described the all together different theory of desire proposed by Gilles Deleuze. The whole discussion in Part I has, in fact, become the evidence that Deleuze is right while redefining desire as a positive force. The proposed theories (the human subject as a 'positively' desiring-machine) supported by the references made to the empirical data allow me to say that desire is about positivity that generates a multiplicity of relations and aims at enhancing the subject's potential. As such, it is morally acceptable. Desire is about the positive emotions-affects transforming themselves into actions, movement, creative alliances and enhancing linkages. Desire does not exhaust itself. On the contrary, it is forever re-generating, it is process and becoming-oriented definitively in love with production. Such theory of desire allows conceptualizing the subject as not attached to the drive aiming at the object so as to consume it and be left with nothing. On the contrary, it allows seeing the subject as located on many 'planes' keeping in hands many lines with no end but immanent vibrations. Therefore, it allows assessing the human's actions in a much more affirmative way, and appreciating and supporting its desires, including those regarding human reproduction.

The proposed theories and manners, concepts and approaches, descriptions and presentations also result in important suggestions regarding the theories in the field of men's studies. The discussion in Part I makes it possible to propose a theory that states that with IVF technique and practice a man can be seen as being much more interested in reproduction than 'production' and who can be much more 'child-oriented' than society thinks. Furthermore, both the feminist and men's studies theories can be enriched with the one stating that with IVF the desire to have and nurture a child does not exclusively belong to a heterosexual couple and that parenthood has nothing to do with destiny but is merely an option. As such, the social pressure on heterosexual couples to deliver babies may, hopefully, significantly decrease.

IVF technology and practice can be used by feminists and those doing men's studies to argue that female and male bodies are not per definition 'reproductively fit'; that ovaries, fallopian tubes, uterus, sperm, tubes and tracks just like kidneys, hearts or livers do not always function in the ways doctors and cultures believe they should. This can be used to deconstruct the equating of the ovary/uterus/sperm with pregnancy. Human in vitro fertilization can be utilized to help women to avoid accusations (when conception does not occur) of not being able to deliver a baby and to help men to change notions regarding their 'always-taken-for-granted' fertility and spare them from mean remarks and jokes. IVF can also be used to make infertility lose its veil of mystery, ambiguity and disability. It is crucial to do so as to ensure that (1) a childless couple will not be a curiosity, something to wonder about (2) the social pressure will diminish (3) woman and man separately and as a couple can be saved from certain 'social' expectations, mean remarks, rejection, condemnation (4) couples will stop feeling 'negatively' different, inadequate and disabled (5) couples' anxiety, depression and feelings of guilt may be minimized (6) couples will become more prone to discuss their situation (fertility problems; participation in IVF) and finally, (7) couples will be able to deal/ live/cope with their fertility problems more easily.³⁶

Conclusion

To see the human as the 'embodied subject in becoming' and to perceive in vitro as a part of a longer procedure where a man is present, is to propose, as described, more accurate and positive evaluation, concepts and approaches to IVF technique and practice. Furthermore, the suggested theories and manners of discussing IVF, recommended assessment, concepts and approaches, together with the descriptions based on the empirical data gathered in the Netherlands and Poland, result in particular recommendations such as the need to constantly examine and critique socius, not to call for a ban on human in vitro fertilization, to positively organize and

³⁶ There are many publications originating from many fields and disciplines that discuss the impact fertility problems may have on the emotional well-being of woman and man (Geer 1995; Hardy & Makuch 2001; Pfeffer 1987; Doyal 1987; Markestad & Montgomery & Bartsch 1998; Imeson 1996; Mazor & Simons 1987). There are different reasons for which certain emotional disturbances appear when conception becomes a problem. There are also various types of emotional responses. However many times those are feelings of difference, inadequacy, disability, shame and guilt that are experienced. Those negative feelings to certain degree appear to originate from cultural/societal norms concerning bodies and reproduction.

explain the phenomenon of IVF or use it to argue for important matters. The proposed manner, assessment, concepts, approaches and description also have an outcome in interesting suggestions regarding theory of desire, feminist theory and men's studies theory.

CHAPTER FIVE

The Incredible Body and IVF as an Assemblage that 'May Be' Followed by the Pregnancy and the Post Partum Period

This Chapter similarly to Chapter Four stands for the empirical-theoretical part of this dissertation. In Part I of this Chapter, I will apply Deleuze's philosophy, Braidotti's and Arendt's theories to my empirical research with IVF couples. Furthermore, by referring to the empirical material I will present that IVF is a procedure that 'may be' followed by the pregnancy and the post partum period. In The Incredible Body and Assemblages, Embodiment, The Incredible Bodies in 'Action' I will describe and explain the concepts and theories I want to apply to my subject/body matter and IVF. Section I will stand for a polemic with the radical feminists. In this Section, I will address female bodies *vis-à-vis* IVF technique/practice. I will talk about connective, external, affective, singular "bodies without organs" and "assemblage(s)" (Section I.I); 'zoe bodies' and "natal power" (Section I.II); the pregnancy and the post partum period (Section I.III). At the end of every sub-Section I will indicate the importance of the applied theories and manners of discussing in vitro for the IVF debate. Section II will become a polemic with the Vatican. In this Section, I will talk about male bodies *vis-à-vis* IVF. I will also focus on female, male and children bodies *vis-à-vis* one another. I will, again, talk about connective, external, affective, desiring "bodies without organs", "assemblage(s)", the pregnancy and the post partum period. At the end of this sub-Section I will argue that only when the proposed theories and manners of discussing in vitro are employed, can IVF be evaluated more positively and accurately. In addition, in Part I (as I have done previously in Chapter Three and Four) I will point out the negative impact the Vatican's policy has had on IVF arrangements in Poland, the way in vitro functions in the Netherlands and the situations of the couples who face reproductive difficulties. In Part II, I will present that the proposed theories and manners of discussing in vitro, the more accurate and balanced evaluation of, concepts of and approaches to IVF but also the descriptions all have outcomes in certain recommendations for the Vatican, the radical feminists, gender and men's studies regarding how to manage IVF. I will also point out that the whole discussion in Part I

results in important suggestions concerning feminist and men's studies theories, in theories 'based on IVF' that can be used to transform existing ideologies, cultural and social norms, beliefs and discourses concerning the matters of reproduction, fertility-infertility, female and male bodies and sexualities, as well as the advanced technologies themselves. In Part II, I will also try to indicate the possibly positive outcomes of the proposed recommendations and suggested theories for all who are facing reproductive difficulties.

PART I

The Incredible Body and IVF as an Assemblage that 'May Be' Followed by the Pregnancy and the Post Partum Period

Less negative and more accurate evaluation/approaches/concepts of IVF technique and practice than those proposed by the radical feminists and the Vatican are possible when the connectivity, externality, perceptivity, affectivity, becoming, deterritorialization, transformative potential and symbiotic abilities, but also singularity of the human body is recognized. Furthermore, it is essential to see the body as a "body without organs" and as a 'zoe-body' equipped with "natal powers". Moreover, if one aims to deliver an adequate and balanced evaluation of, concepts of, and approaches to IVF technique and practice, in vitro has to be perceived as an "assemblage" (that is 'always already' becoming another "assemblage") and as a plane of immanence which the human body is an element of. Next to that, the body should be seen as the base, the *sine qua non* of the human being's subjectivity. In addition, it must be kept in mind that the productive desire and desiring-production are intrinsic to every human subject (see also Chapter Four). Furthermore, I also want to argue that proper assessments of IVF technique and practice can only be reached when it is not forgotten that the pregnancy and the post partum period may follow the IVF procedure.

The Incredible Body and Assemblages

At the very beginning of this Chapter I have used certain expressions that may sound a bit ambiguous if not all together recondite and uncanny. Good, I would say, because what sounds like a riddle can actually be quite thought provoking. However, to avoid creating too much of a puzzle, I want to shed some preliminary beams of light on the wording I have employed.

Those who analyze any type of the phenomena in which the human being is involved must take its enormous complexity into account. In Chapter Four, while discussing the human being, I have stepped onto theoretical ground occupied by various scholars such as Braidotti, Deleuze, Colebrook or Grosz and frankly I would like to remain there. This is because their concept of the human body/subject, in my view, reflects most adequately the ‘real’ condition of the contemporary human being. In the former part of my research I have talked about the human subject as “(...) *energetic, forever shifting entity, fundamentally driven by desire for expansion towards its many-faceted borders/others*” (Braidotti 2006:131). I have also emphasized the embodied ‘nature’ of every human subject. In this part, I will once more refer to those theories, yet I will deepen my former discussion regarding human embodiment. In addition, I will concentrate on other peculiarities of the human body. The body as comprehended and described by the listed scholars appears to be a fantastic territory of endless possibilities and a ground of/for fascinating experiences. What the body can do is a question without an easy answer as the body can apparently do quite a lot.

Embodiment

My understanding of the human body remains in line with the above mentioned scholars. To me, the body stands for the very materiality of, to name just a few, organs, tissues, veins, nerves, billions of various cells, including neurons and neuroglia, genes and chemical substances such as neurotransmitters and hormones. There are countless connections and not always easily predictable interactions. There are endless transmissions in constant motion. Yet, talking about the body in this way I do not want to add to the old rhetoric, which equates the body with meat or flesh that is inferior to the mind. On the contrary, to me, the body is the material that is the basis of perception, cognition, emotion and memory. Braidotti writes, “*With reference to molecular biology, genetics, and neurology – to mention just a few – the body today can and should be described adequately and with serious credibility (...) as a sensor, an integrated site of information networks. It is also a messenger carrying thousands of communication systems: cardiovascular, respiratory, visual, acoustic, tactile, olfactory, hormonal, psychic, emotional, erotic. Co-ordinated by an inimitable circuit of information transmission, the body is a living recording system,*

capable of storing and then retrieving the necessary information and processing it at such speed that it can react 'instinctively' (...) The body is not only multifunctional but also in some ways multilingual: it speaks through temperature, motion, speed, emotions, excitement that affect cardiac rhythm and alike" (2002:230). It is the body, the material, that makes the human sense, translate information transmitted from the sensing organs, laying the basis for the processes of thinking, reasoning and other conscious and unconscious mental processes. It enables the experiencing of emotions; it remembers. It is the material that is the foundation of one's subjectivity. As clarification, I want to stress that while emphasizing the importance of the body, of the material I am in no sense in favor of biological determinism. On the contrary, I will never agree with it. The body, as I will contend later in this Chapter, is grounded in its materiality, but it is also an "*eco-logical entity*" (Braidotti 2008:182) what means that it constantly connects with its environment. The materiality of the body remains in motion and there are millions of different internal interactions that have unpredictable outcomes. At the same time, the body endlessly undergoes various encounters with its surroundings and the results of such cannot be effortlessly anticipated. Thus, if the body is "*(...) a script written by the unfolding of genetic encoding [but also] a text composed by the enfolding of external prompts*" (Braidotti 2008:180) isn't the idea to remain faithful to biological determinism rather moldy and out of date? I do think it is.

The Incredible Bodies in 'Action'

Grosz argues that for Deleuze "*Following Spinoza, the body is regarded as neither a locus for a consciousness nor an organically determined entity; it is understood more in terms of what it can do, the things it can performed, the linkages it establishes, the transformations and becomings it undergoes, and the machinic connections it forms with other bodies, what it can link with, how it can proliferate its capacities – a rare, affirmative understanding of the body*" (Grosz 1994:165). Following Deleuze's ways of arguing, subjects are fueled by desires. At the same time, the human body 'co-exists' with all the elements of the reality surrounding it. The inherence/constructivism of desire and the 'co-existence' specific to bodies indicates the constant presence of "assemblages" which the body is part of. The presence of the "assemblage", but also of desire, is essential for the body to make

connections and alliances. An “*assemblage*”, as conceptualized by Deleuze is, to put it simply, a space where bodies, ‘things’ or, in fact, ‘anything(s)’ that happen to be there, meet. Furthermore, one assemblage can very quickly turn into another one. Because an assemblage is quite a ‘crowded space’ and because desire being a positive, inexhaustible force intrinsic to ‘every-body-subject’ that is aimed at endless creation ‘never sleeps’, bodies start to connect and the ‘outside life’ starts rushing through them. In this way the body can be referred to as external and affective. Braidotti recognizes and addresses this in a very brisk manner stressing how the body “(...) *captures the outside world by making itself receptive to the totality of an assemblage of elements, in an almost geographical or cartographic manner (...)*” (Braidotti 2006:145). The body, ‘things’ and ‘anything(s)’ ‘bump’ into each other and rush through each other. As they ‘bump’ and rush through, they become, change, transform and undergo metamorphoses. Nothing stays the same way. The bodies experience nonhuman becomings. Deleuze points to this while saying that, “(...) *we become with the world (...)* *We become universes*” (Deleuze 1994: 169). The moment becomings, transformations and metamorphoses take place the assemblage can be referred to as a plane of immanence. This is because everything that happen qualifies as a “*radical immanence*” that is “(...) *the field of forces, a quantity of speed and intensity*” (Braidotti 2006:126). The presence of assemblages and the ability of the bodies to connect allow percepts and affects to enter the scene. Bodies are both magnets for percepts and spaces crowded with affects. They are not only populated by the ‘incoming-at-present-percepts’ and ‘circulating-within-at-present-affects’, but also by those percepts and affects ‘saved-and-stored’ in the bodily ‘memory-banks’. “*Affects*” are “*independent things*” (Colman 2005:11). The pressure of the lamps’ light on somebody’s eyes, the visible shapes, the sensed/perceived tactile leather, the smooth texture of the chair’s seat or audible voices carrying information all ‘qualify’ as affects. The body makes room for percepts, embraces them, and ‘swallows’ them and then gets affected and enables affects to further produce. By embracing percepts, the body becomes; it becomes affected, transformed possibly to the point of imperceptibility. “*In those moments of floating awareness when rational control releases its hold, ‘Life’ rushes on towards the sensorial/perceptive apparatus with exceptional vigour*” (Braidotti 2006:145). As such, bodies “*coincide with nothing more than the degrees, levels, expansion and*

extension of the head-on rush of the 'outside' inwards" (Braidotti 2006:145). The body is affected/transformed/imperceptible in a sense that it does not remain the way it was a second before and that it constantly 'reaches the status of something else', as Deleuze explains, "*Affects are precisely these nonhuman becomings of man (...)*" (1994:169). Furthermore, when the body becomes, to put it simply, a kind of 'third quality-entity' emerges. "*Becoming is neither an imitation nor an experienced sympathy, nor even an imaginary identification. It is not resemblance. Rather becoming is an extreme contiguity within coupling of two sensations without resemblance or, on the contrary in the distance of a light that captures both of them in a single reflection (...)* It is the zone of indetermination, of indiscernibility, as if things, beasts and persons (...) endlessly reach that point that immediately precedes their natural differentiation. This is what is called an affect." (Deleuze 1994:173). Yet, the body though external, symbiotic, and in-becoming also remains singular as it is "*(...) both unique and common, both an entity of its own perceptual data and a ground for the relation (...)*" (Conley 2005:252). The assemblage is not only a space where bodies and 'things' interact. It is also a territory where two or more bodies can meet. The inevitable proximity, forceful and productive desire are the prelude for the 'oncoming' connectivity. The moment connections of any type take place; the moment percepts enter the scene, the affections and becomings always follow. "*Affect*", as Coleman explains, is "*(...) physically and temporally produced*" (Coleman 2005:12). To put/explain it simply, using uncomplicated examples, percepts can produce affections (i.e. sunlight entering the body and the body becoming 'warmth', a 'sun-touched-body'). Affects are produced as the result of various encounters: "*Affect is the change or variation that occurs when bodies collide, or come into contact. As a body, affect is the knowable product of an encounter (...)*" (Colman 2005:11). While being produced, affects themselves can produce and launch a 'chain reactions' with unforeseeable outcomes as they are able to "*(...) inform and fabricate desire, and generate intensity (...)*" (Colman 2005:12) (i.e. a 'warmth' of the body', a 'sun-touched-body' results in the strength to continue walking on a cold and gloomy winter day). In this sense, affects can be understood as forces, as a power (*potentia*) that "*(...) can be utilised to enable ability, authority, control and creativity*" (Colman 2005:12). Certainly, the body is always a part of 'some' assemblage, it is a 'space' that produces affects and where affects are

produced. Whenever becomings and transformations occur the body might also get dismantled. This is not to say that the body literally falls apart or cracks down into the pieces. It basically indicates that the body can be, can arrange itself, can feel, can act and behave in the ways, which are not expected or better biologically, culturally and socially prescribed and assigned to it. The affected/becoming/transformed body can become a dismantled body. It can become a “body without organs”. A “*body without organs*” is, as Braidotti emphasizes, a Deluzian “(...) *vision of the body as un-organic: a body without organs, a body freed from the codes of phallogocentric functions of identity. The un-organic ‘body without organs’ (...) [is] freeing organs from their indexation to certain prerequisite functions: this is the process of becoming animal. In some ways, this calls for a generalized perversion of all bodily functions not only the sexual ones (...)*” (Braidotti 2002:124). The human body is also a territory where “*zoe*” “*second best (...) the idea of life carrying on independently of, even regardless of and at times in spite of, rational control*”; “*unfolding of biological sequences*” ‘operates’ (Braidotti 2002:132). As “*zoe*” is also a generative power and a generative force (Braidotti 2006: 41), it brings with it the idea of life as a creative, productive and continuous process. Thus, I can say that the ‘*zoe*-body’ has in itself the potential to prolong itself, to produce, to generate and to begin life. In my view, such perspective of life and the human body is very close to Hannah Arendt’s concept of “*natality*” and “*natal power*”. “*Natality*” is “(...) *the most general condition of human existence*” (Arendt 1998:8). “*Natality*” is about “(...) *the constant influx of newcomers who are born into the world (...)*” (Arendt 1998:9) and the fact that “(...) *new men, again and again appear in the world by virtue of birth*” (Arendt 1981:217). The human may die but human life is not about dying, or destruction or mortality (mortal power that is *potestas*) but the ability to create, produce, begin, prolong itself and last (natal power that is *potentia*). “*The purpose of the creation of man was to make possible a beginning (...)*” (Arendt 1981:217). The human body equipped with natal power is entitled to creativity, production, generation and to begin life. “*The life span of man running toward death would inevitably carry everything human to ruin and destruction if it were not for the faculty of interrupting it and beginning something new, a faculty which is inherent in action like an ever present reminder that men, though they must die, are not born in order to die but in order to begin*” (Arendt 1998:246). To be born, is to be able to

act, thus natality indicates action and as such is “(...) *inherent in all human activities*” (Arendt 1998:9). According to Arendt, the human capacity to act “*by virtue of being born (...) bestow[s] upon human affairs faith and hope (...)*” (Arendt 1998:247). Furthermore, the body is definitively, to repeat it once more, a *sine qua non* of the human subjectivity and everything that ‘happens’ to the body and with the body, everything that the body does, immediately becomes “*constitutive of embodied subjectivities*” (Braidotti 2002:160).

SECTION I

Women/Female Bodies and IVF Technique/Practice

In a Polemic with the Radical Feminists

SECTION I.I

Landscapes of the Finest Selection of Difference I

The Becoming of Multitude, of ‘Everything’

Nowadays, hospitals, private clinics medical centers represent territories ‘crowded with’ the most advanced, though sometimes not so progressive, depending on the geo-political locations, techniques, methods, treatments available. These are applied in order to measure, check, diagnose, and possibly fix the body of the human subject. Every technique and every method has a particular toolbox in order to do so. This toolbox is filled in with the most sophisticated, though sometimes quite simple, tools. The tools can vary. They can be medicines in the shape of pills, but also liquids which enter the body when drunk or injected. In addition, almost every technique and every method applied depends on the usage of a machine, an apparatus employed to examine, investigate and to visualize the human body. It is a real challenge to name and describe all of them. However, to give an idea of what can be encountered in the world of medicine nowadays, we can think of microscopes, ultrasonographs, roentgen apparatus, laparoscope, life supporting machines, dialysis machines as well as many others. In short, at present, medical centers form technological landscapes that are highly populated with nonhuman actors. The presence of technology is simultaneously visible, audible, and tangible and, though it may sound like an exaggeration, it has its own particular scent. Undoubtedly, the medical territory, enclosed in various buildings scattered all over the world, is not just about pills,

liquids circulating in transparent tubes, and persistently operating machines. Contemporary medicine is also a space where human existence can easily be traced and when various techniques become practices with widely opened toolboxes. The medical staff forms an intrinsic part of the present medical institutions. To complete the picture, one must include those for whom those institutions have been created in the first place, meaning the patients. The medical centers are the result of desiring-productions of various sorts (i.e. understanding, knowing, healing and/or being healed). They are also the territories where both human and nonhuman actors simultaneously co-exist. Therefore, they stand for interesting assemblages with an appetite for immanent plateaus.

Human in vitro fertilization (IVF), offered in countless medical institutions all over the world, stands for a particular technique with its own toolbox. There is sometimes, though not always, trained medical staff. In addition, there is quite a number of participants expressing the wish for an offspring. I have already thoroughly described the IVF protocol. Therefore, now I will only refer to it briefly to facilitate the oncoming discussion. The first tools used from the IVF toolbox are the hormones that the female participant is injected with. There are situations, especially as practiced at the Dutch hospitals, when the 'natural' menstrual cycle is preserved and when drugs are not used but the injections are practiced in most cases (certainly in the clinics where the interviewed Polish couples did their IVF). The hormones are supposed to firstly suppress the 'natural' cycle and then stimulate the growth and development of more than one egg cell. In order to observe the growing/maturation of the follicles the female participants must remain under constant observation and have blood tests and ultrasound scans done. The moment the doctor decides that the size and number of egg cells are satisfactory, they must be removed from the female's ovaries. The aspiration can be done under anesthesia (Poland) or without (the Netherlands) with a needle placed by doctor in the vagina and performed under ultrasound guidance. The liquid removed from the ovaries is put into a test tube and sent to the laboratory where sperm is mixed with (Classic IVF) or inserted in (IVF-ICSI) the egg cells. Embryos that possibly develop from the fertilized eggs are placed by a medical practitioner into the female uterus through cervix with a help of a plastic catheter.

It may appear that the IVF technique and its toolbox, the medical staff putting it into the practice and the female participants are separate entities. It can even seem that if they are brought together their clearly defined and drawn borders protect them from dissolving into one another. They only 'brush' and 'stroke' each other. Their borders are impenetrable and nothing can go through them. There is a machine, a needle, a doctor/nurse doing its job and a female participant. That's it. Even when the interaction occurs it can appear that while it takes place, the 'wholeness' and so to say the 'prescribed'/'assumed' identity of all the parties involved remain unchanged and untouched. The mutual encounter may be understood as an event where three things, differencing in matter, meet and yet remain 'bordered'. They stay separate, discrete and tightly enveloped in their 'obvious' distinctions. The doctor checks for the growth of the follicles. The machine visualizes female's ovaries. The patient lies on the special chair: the doctor, the machine and the patient. They all certainly interact yet they maintain their separateness and 'prescribed'/'assumed' identity was before, during and after their mutual encounter. This is how it may look like at first sight.

At the second glance, the 'picture' may take on completely new characteristics. Instead of the crystal clear and formal 'beton' of sterile bordering and 'block-like' identities, one may spot a genuine mosaic of undetermined, untold, unexpected, not anticipated and unknown 'shapes-non-shapes', 'forms-non-forms' and 'figurations-non-figurations'. I will try to prove this in the following part of this Chapter so to eventually come up with the possibly more positive and accurate assessment, approaches and concepts of IVF than those proposed by the radical feminists.

The Bodies. The Assemblages. The Figurations

Assemblages

Desire, as explained by Deleuze (1988-89) and presented by Charles J Stivale (2004), is absolutely necessary for the construction of an assemblage. Human in vitro fertilization could have never happened if that were not for the desiring-production which intrinsically consists of various objects of desire (i.e. understanding of the working of the human reproductive system, researching the ways of creating

embryos outside the body and exploring possibilities of having a child). In this sense in vitro can be easily conceptualized as an assemblage. Furthermore, "*Assemblages (...) are heterogeneous, disparate, discontinuous alignments or linkages brought together in conjunctions (x plus y plus z) (...) assemblages are the provisional linkages of elements, fragments, flows of disparate status and substance: ideas, things-human, animate, and inanimate (...)*" (Grosz 1994:167). The IVF indicates the presence of a particular technique and its toolbox, medical staff and female patient. Thus, again it can be seen as an assemblage. In addition assemblage "*(...) is, like the contraption or gadget, a conjunction of different elements on the same level (...)*" (Grosz 1994:167). When the IVF takes place, all the elements (technique with toolbox, medical staff and female participant) are essential and there is no doubt that one element cannot do anything without another. In this sense, they are 'equal in status'. This 'equality' again indicates that this is an assemblage. Every assemblage, as seen by Deleuze (1988-89), "*(...) implicates processes of deterritorialization, movements of deterritorialization*" (Stivale 2004) or, as I have already emphasized, of becomings and metamorphoses. This implication of possible deterritorialization at the same time indicates the probable creation of the plane of immanence that is precisely all about transformations. Following the logic of the assemblage, everything that is there enters the processes of becomings.

Desire and Connectivity

In Chapter Four I have already presented that every female participant that entered the fertility centers was involved in the desiring-production of which the object of desire is a child. In this sense, as suggested above, her desire constituted the basis for in vitro which is an assemblage as desire is crucial for the formation of assemblages. In Chapter Four I have also indicated that every human subject is fueled by desire. This desire manifests itself in the fact of the subject's body being prone to connections and alliances with its surrounding reality. The participation/presence in the assemblage, but also the presence of desire, enables the human body to connect, to make alliances and to produce linkages. Every woman, I talked to, who happened to come into contact with doctors/ nurses or some sort of contemporary medical devices made her body 'ready' for the possible encounter. This 'readiness' was an

outcome and a result of being in/sharing the same space with the medical staff and the medical equipment, as well as the woman's desire to have a child.

Mon had never visited the hospital. She had always been very healthy so she had rarely been to a doctor. She had never had any major injuries, injections or been put under anesthesia. She did not like medical institutions and she was afraid of them. However, in spite of this fear and inexperience, the fact she was there and her desire for a child enabled her to interact with doctors and tolerate the strange spaces, medical tools, procedures and machinery. It also enabled her to take injections and to accept drugs such as anesthesia for egg cells aspiration. Mia was not very keen on hospital settings either. She was worried about the impact hormones may have on her body and health. However, it was also her wish for a child and the presence of medicines that made her ready for the change in the chemical composition of her blood. Bian felt negatively about the machinery of contemporary medicine. Yet, she did not want to live with a wish for a child instead of a child itself. Knowing that the liquids and the 'tricks' of the technique could possibly help, she decided to, as she put it, "*stretch her borders.*" Sylva did not have any problems with medical institutions and their particular protocols. For many years, due to her health issues, she had been 'linked' to and interacted with various liquids, pills and machines. From the moment she found herself in the fertility clinic, she communicated with the doctors but also made her own alliances with the ultrasound scans, laparoscopic mapping, hormones flowing and needle-egg-collection. Ane had never had to wonder about, as she explained it, "*the insides of her body.*" She had never been to the hospital and had never experienced any type of medical intervention. The world of bodies 'in need of repair', was not hers. "*The whole world was like arranged*" she said. Ane also did not like the idea of anyone or anything "*going inside of her.*" Yet, being in the clinic and desiring a child, she got involved in the patient-doctor dialogues and became open for scans, laparoscopy, injections with hormones and a needle extracting fluid from her ovaries. Tru knew she could have had difficulties when it came to getting pregnant. There were similar problems in her family and among her relatives. Being in the clinic and facing doctors she reached out to them and they, as she said, "*took her by the hand.*" Tru, in return, took the scans, the hormones and allowed the needle to get through her ovaries. The presence of the

assemblage and the positive power of desire made each of these women open up, connect, make alliances and produce linkages with her surrounding reality (in this case IVF reality).

Perceptive and Affective Bodies

Being a part of an assemblage and fueled by desire, the human body connects and makes alliances. By reaching out and linking itself to the outside world, the body rich in its 'former' percepts/affects and the basis of subjectivity, becomes external as it becomes this very world. It becomes external precisely because the 'outside', when rushing through the body happens to form a part of an 'inside'. To become a world, to have a piece of external life inside is to embrace and absorb in oneself a nonhuman element. The exercise of embracing and absorbing the nonhuman ingredient(s) can be seen as a transformation and becoming, and to be more precise, a nonhuman-affective becoming of the human body. The interviewed women who got acquainted with the labyrinths of the IVF clinics made their own alliances and connections with different elements of the assemblage. They themselves constituted an intrinsic part of this assemblage. Though the assemblage consists of many fragments, bits and pieces, in vitro technique and its full toolbox stand for those elements with which the linkages were unavoidable. Every woman felt the moment the needle went through her skin into the vein to fill the syringe with blood for hormonal analysis. There was 'no-body' that did not sense/perceive the gel spread over the abdomen to facilitate the ultrasound scans. 'Some-bodies' sensed/perceived the laparoscope sliding inside and 'some-other' felt the liquid slowly flowing to the uterus and moving further to the oviducts while the hysterosalpingography was performed. 'Some' sensed/perceived the needle pricking the ovaries and 'some' the tranquilizing drugs injected before the aspiration took place. All captured the plastic catheter placing embryos inside the uterus. The gel, the laparoscope, the liquid, the needle and the catheter all were sensed, captured, perceived, and as such, they became a part of the body. At a certain moment in time the 'outside' was temporarily turned into the 'inside', into a part of the female body. The moments of sensing, capturing and perceiving the gel, needle, laparoscope or catheter were moments of peculiar transformation, of the becoming-a needle-a laparoscope-a catheter; moments of the nonhuman becomings of the female body.

Nonhuman Becomings

Every assemblage can very easily turn into another one. An assemblage is also a space, a territory with restlessly and constantly circulating percepts. Percepts of various types enter the human body and produce/trigger/create transformations, affections/affects, nonhuman becomings and zones of indetermination and indiscernibility. The moment percepts get into the body, already full with the 'former' percepts and affects and being the foundation of subjectivity, the body undergoes metamorphoses and deterritorialization, thus it does not stay the same way as it was the minute before the encounter. It undergoes transformations and deterritorialization as it becomes affected, and thus experiences nonhuman becomings. It also, to repeat, undergoes transformations and deterritorialization as it becomes affected and the zone of indetermination is created. The formation of such zone, to put it simply, indicates that a type of 'third quality-entity' emerges. There is no longer the body itself or the percept. 'Something' in-between, 'something' new, 'something' different, 'something' original and unrepeatable: an affect is created. The incoming percepts as well as the produced affects can have much in common yet every-body becomes affected differently. This is because bodies are singular and unique in their perception(s), interactions with and selection of percepts and selection of affects. At the same time, when the percepts circulate within the assemblage and trigger affections and becomings of different kinds, it is not easy to predict or anticipate what 'types' of percepts will come into play. Nor is the shape, the form of what can be created, or how this 'something' in-between, the affection, might possibly 'look like'. Everything that the assemblage consists of has *"(...) the same ontological status. There is no hierarchy of being, no preordained order to the collection and conjunction of those various elements no central organization or plan to which they must conform"* (Grosz 1994:168). What is more, *"(...) an assemblage follows no central or hierarchical order, organization, or distribution (...)"* (Grosz 1994:167). Every affect is a force, a spark and an engine that triggers production, that, to repeat, *"(...) can be utilised to enable ability, authority, control and creativity"* (Colman 2005:12).

For the female participant who started in vitro, IVF became constantly present and it became part of her life. The female body, doctors/nurses and the technique with its

toolbox (liquids, pills, scans, machines, needles, tubes, etc.) remained tightly and constantly connected for a relatively long period. Even when the landscape was changing from the medical clinic to the city, village streets, to home and back to the clinic, IVF and its elements did not lose their junction and particular fusion. Yet, with the changing landscapes it becomes clear that IVF ‘spread in space and time’. Therefore IVF and its elements became endlessly enriched with other fragments, bits, and pieces surrounding the female body’s ‘reality’. When IVF took place, countless percepts were set into motion and moved straight into the spaces of the female bodies. The warm tone of a doctor’s voice, a comforting touch of a nurse’s hand, a wide smile of a practitioner performing ultrasound scans, the positive vibrations of a said aloud “*good luck*”, “*do not worry*”, “*it is going to be ok*”, “*the next time will be better*” or “*congratulations*”; the sound of the steps of the doctor carrying the embryos, were all sensed, literally ‘sucked in’ and perceived. The very moment such sensations appeared, the female body became this warm tone, comforting touch, wide smile and positive vibrations. The inhumanities got into the human spaces and launched affections, transformations, metamorphoses, deterritorialization, in one word, nonhuman becomings. A glance and a prickle of a needle, a pressure of liquid entering veins, a touch of an ultrasound probe and a blur of an ultrasound monitor were also captured and perceived and as such stood for the female body’s affects/nonhuman becomings. IVF spreading over time and different places/locations preserved its own elements while constantly embracing new ones. As a result, more percepts could come into play, a visible and tactile luminosity of the sun the day the hormonal stimulation was commenced, a tactile warmth of a Christmas tree lights when the results of fertilization were still unknown, a visible shape of a stork walking by the road spotted when driving in the car for the embryo transfer - the capturing, sensing, transmitting and perceiving female body, a territory of interesting affections/nonhuman becomings.

Mia’s body and the hormones she injected, together created the affect of a well-being. The body and the medicines merged together turning into a new positive quality, the affect of happiness. “*Hormonal shots made me really happy.*” As such Mia faced her ‘difficult reproductive situation’ in a much more relaxed way. The junction between Mag’s body and the injections resulted in the affect of joy, which

on the other hand, allowed her to continue and to believe in her success. For Jus, Bo, and Lid the connections between their bodies and their medications were not so positive. They all became anxious, annoyed and frustrated affect. As a result, they phoned their doctors indicating the negative side-effects and asking for advice but also suggesting a change in the prescribed medications. Lid, even, stopped taking her pills without medical consultation. For El, the body and shots connections had an outcome in her becoming fearful. *“Taking medicines at home, I was sometimes scared that something would go wrong.”* The junction of Mari’s body and the needle during the egg cells aspiration but also Justy’s bodily connection with the liquid injected during hysterosalpingography (contrast material, i.e. saline) did not have a positive result. Mari’s becoming the ‘needle-prickled-body’ and Justy’s becoming the ‘saline-flowing-inside-body’ was a becoming disgust and suffering. They became the affect of disgust and suffering. Mari said, *“I wanted this to be out of me.”* Bo’s becoming the ‘needle-touched-body’ was a becoming hatred. *“Awful. I hated it.”* However, Syl’a’s becoming the ‘needle-touched-body’ was a becoming acceptance. *“Aspiration was very hard. They wanted to make me sleep. I did not want that. I did not make a sound.”* Interestingly, those affects resulted in very positive actions of perseverance and endurance, but also in loudly expressed opinions. Tru, who went through similar becomings as Mari and Bo, said *“At one moment I took a deep breath and afterwards I told him [a doctor] that ‘it was not nice’.”* Mag was under anesthesia when the aspiration took place. She became the ‘tranquilized-expectant-body’. The affect of hope, gratitude and happiness allowed her to strongly believe that she would win her ‘reproductive battle’. *“I felt asleep with a smile on my face. At that moment I was so happy.”* The medical staff’s empathy, the taste of the warm soup given after egg aspiration turned Dus into the ‘warm-soup-cared-about-body’. The affect of happiness and comfort enabled her to remain strong and, most of all, optimistic. The doctor’s empathy and audible questions such as *“why do you cry?”* or *“can we look at your body?”* made Jus become the ‘spoken-to-cared-about-body’. The affect of gratitude added significantly to Jus’s remaining positive. One day Tru was driving to the hospital. She saw a bird, a stork which is culturally believed to bring children. In the context of the oncoming embryo transfer, the appearance of the stork resulted in Tru’s becoming the ‘embryo-transfer-seeing-stork-body’. The affect of happiness resembled champagne, bubbling and sparkling. It was a positive

'bubbling', full of hope and love. She accelerated, not only the speed of her car, but also the 'speed' of her involvement in the whole procedure. *"It was so busy on the road but there it was. For me it was like a sign."* Every phone call Mari made or received became important. The audible voice was registered and Mari became the 'spoken-to-body'. The affect being sometimes pleasure and sometimes sadness and grief. By experiencing pleasure, she was no longer scared; experiencing sadness she talked with her closest friends and relatives. For Mari, as for all the other women, the passing time but also the warnings that the embryos may or may not develop resulted in their becoming the 'having-not-having-embryos-body'. The affect of joy and fear, hope and anxiety turned into talking with friends/relatives, reading, taking a walk, getting preoccupied with work or domestic activities. The audible voice that informed about the number of created embryos caused their becoming the 'spoken-to-having-embryo(s)-body'; the affect being euphoria and gratitude. The possibility of seeing embryos [the Polish women], the steps of the doctor carrying embryos, the shape and the touch of catheter with embryos, the audible warning that the embryos may or may not developed into fetuses and later on babies resulted in the becoming the 'getting-(?)-having-(?)-embryos-body', the affect of doubt or, on the contrary, uppermost happiness turned into Mari's *"I knew that I did not have to succeed the first time. I did not have much expectation in order to protect myself. I really said that the first time is to try"*; Bian's *"I did not have my hopes very high for the second time"*; Justy's *"I wondered if they going to settle, if it is going to work"*; Dus's *"You do not want to hope too much. You believe that it might work. This might have a chance. You do not want to put your hopes too high. You do not want to put much attention because it may go wrong"*; Bea's *"I told to myself that it was not going to work. I was sure I was going to fail"*; Viol's *"I was trying not to get psychologically involved. I kept my distance"*; Jus's *"When they put embryos back you have a feeling that you are 'a little bit pregnant'"*; Syl'a's *"You go out. You feel them. You think I am pregnant now"*; Mag's *"The moment they put the embryos back I knew I am pregnant. There was any possibility of me not being pregnant."* At one particular moment, Syl'a was very worried that she had only three egg cells to get fertilized. Then she looked at the calendar and registered that the aspiration had taken place on Good Friday, the Friday before Easter. That date; the oncoming Easter; Easter's promise of 'new life' and rebirth; Easter eggs; the eggs 'taken from her' resulted in

her becoming the 'Easter-eggs-her-taken-eggs-new-life-body'. The affect of hope and love turned into Tru's significant release of stress. "*Easter Egg. Good Friday, eggs, new life (...) We were very happy.*" Vio had lost her first pregnancy, after Christmas. One year later, when she was just after the embryo transfer she did not want a Christmas tree with its sparkling lights. The recently implanted embryos and the glitter of the Christmas lights resulted in Vio's becoming the 'sparkling-lights-lost-present-lost-again(?)-embryos-body', the affect of fear and anxiety. Jus used to cry when things went wrong. A nurse's touch on her shoulder or the voice of a practitioner made her become the 'body-that-was-touched', the 'touched-body', the affect of hope and love. Because of that, Jus felt strong enough to carry on, to continue. A nurse shaking her head "*no*" [pregnancy] made Ali the 'no-head-sign-pregnant-body'. The affect of sadness and grief but at the same time the comforting hands of relatives turned Ali's body into the 'uplifted-one'; the affect of hope that allowed her to go on. The piece of paper with 'not pregnant' and the 'turned back posture of a nurse' made Magg to become the affect of horror and loneliness.

There were many percepts circulating between the parties involved and equally many affects produced. The affects of fear, to put it simply, turned into women enriching their knowledge, reaching the level of an IVF expert (knowing names of medicines, medical definitions of the body interior). Dus said "*We were trying to make it nice. I have a lot of humor.*" Therefore, it is of no surprise that the affects of anxiety and doubt many times turned into 'jokes' regarding medical staff, medical procedures and techniques but also of their 'own' participating bodies' "*I produced very little eggs*" [Ew]; "*Then the time for X-rays. A buddy is coming in a white gown and I am sitting there like 'I'm on the plane'*" [Ew]; "*Getting to know how many eggs I had I was 'shocked with hope'*" [Mag]; "*I asked the man in a lab to choose the most 'extra' embryos for us*" [Mon]; "*Swim!*" [Dus' partner during fertilization]; "*Shake it and make a party*" [Tru's partner during fertilization]. The affects of gratitude, love and happiness or the affects of grief and regret transformed into oblivion of what was going on. "*When I saw water, liquid in a kind of a bowl [embryos before transfer] my feelings were amazing. I had eyes full of tears. (...) I did not know the proper medical terms; I did not know what he [doctor in the lab] was saying*" [Mag]; "*I cried after every loss [when there was no pregnancy after embryo transfer] I do*

not remember how many transfers I had. I guess a lot. All the memories are fading. They become very distant. I forgot. I do not remember” [Bea]; “Heavy. I felt so heavy. I erased it all from my memory (...) I do not remember anything even the names of the medicines that I took. It is maybe because I do not want to remember, I do not want to think about it” [Mon]; “I used to remember all the medical terms but now I do not” [Ali]; “It does not mean anything. IVF is the past. Nothing when I look at my children” [Fos].

Bodies Without Organs

Assemblages go hand in hand with becomings, transformations and deterritorializations of different types. Assemblages may also result in the ‘formation’ of dismantled bodies, the bodies without organs. The body without organs, as already explained, is a body whose organs no longer function as the culture wants them to, the body that ‘develops’ and becomes ‘enriched’ with new organs and the body whose organs take over functions from the other ones. *“The body without organs is not a dead body but a living body all the more alive and teeming once it has blown apart the organism and its organization(...)”* (Deleuze and Guattari 1987:30 in Grosz 1994:169). The organs of the dismantled bodies can become ‘lazy’ or ‘resentful’ towards the culture with its demands and requirements. They can also become involved in other activities. Every interviewed woman who entered the fertility clinic came to know that her organs, or the organs of her partner, had become rebellious and did not want to perform as they are generally ‘supposed’ to. IVF, the mutual cooperation of the female participant, doctors and the technique with its toolbox does not ‘fix’, ‘correct’ or ‘convert’ the ‘opposing’ organs. On the contrary, the ‘rebellious’ organs are accepted and moreover, in a sense ‘ignored’. Such ‘actions’ only push the dismantling further, turning the bodies into truly ‘organ-less’ ones. Certainly, the organs defined as reproductive (ovaries, oviducts, uterus, vagina, testis and penis) still play a very important role but their performance is significantly changed. The ovaries produce egg cells yet only in the duet with hormones. The fallopian tubes allow ‘eggs out’ yet in the joined cooperation with an aspiration needle kept by a practitioner. The uterus hosts embryos but after the encounter with a plastic catheter held in a doctor’s hand. Technique and doctors become new organs when it comes to assisted reproduction making, as said, the

participating bodies 'organ-less'. The bodies are 'organ-less' because those are no longer *sensus stricte* uterus and penis facilitating fertilization/creation of embryos though their 'presence' and 'participation' is both inevitable and essential. The bodies become organ-less as they 'grow', 'develop' and get 'enriched' or 'equipped' with new organs responsible for reproduction. The silently and apparently non-working/functioning organs have usually been in charge of the conception, development of embryos and the body signaling its changed state (pregnancy). Assisted reproduction, the mutual collaboration of the three major elements, makes also other organs in charge. Those are the eyes and the ears that join the 'group' and so the embodied subject becomes fully aware of what is going on. All the female participants knew approximately the time when the fertilization was taking place. They were also aware of embryos being placed in their uteruses. The Polish women had also a chance to see their embryos enlarged and displayed on a computer monitor. They all knew that they had embryos inside and when to do the pregnancy test. They equally knew that even with having embryos transferred, they could be either pregnant or not pregnant. The female participants were entirely conscious and aware of what was happening and the possible outcome(s). Due to this, some of them were absolutely sure they were pregnant even if they did not sense the typical for pregnancy symptoms (i.e. delayed menstrual cycle; swollen/tender breasts; tiredness; morning sickness). The moment Ali saw the "pipe" (as she said) with embryos she felt that in this very "pipe" there was nothing else but "life." When Magg saw her embryos on the screen she felt pregnant on the spot. Tru, knowing that she had had embryos, transferred was also almost sure she was pregnant. *"When I came home from the hospital, I thought that it could have been now. When they put them [embryos] back, I had big hopes. I had immediately the feeling 'yes, this was it'."* Mag and Mon had very similar sensations after their embryo transfer: *"I immediately felt pregnant. I felt as if I was about to give birth the very next day"* [Mag]; *"After I had got them when I was driving home I felt that I was pregnant"* [Mon]. The awareness also made some of the women actively look for the pregnancy symptoms. *"You had them. I felt very strange. At that moment you were pregnant. (...) I read in the book for the signs (...) I looked [at her body] and found them"* [Syla]; *When they put them back I felt that I was pregnant. I was looking for symptoms."* As I have said, to see embryos on the monitor [the Polish participants] and/or to sense the

catheter was to become aware of processes that usually go unnoticed. As a result, knowing that there was a chance that the transferred embryos might have settled and that there was a possibility of becoming pregnant, some were confused as they did not sense the learned about and expected signals/affects. *“You know that you are becoming pregnant and many people do not know that. You are more aware of what is going on”* [Mia]; *“You have them [the embryos]. I felt very strange. At that moment you are pregnant. I did not feel different. I was afraid I was not pregnant. I did not feel pregnant”* [Syla]; *“Two embryos. They put them back. It was very weird. You are very aware of it. You think that maybe I am pregnant. I did not feel pregnant but I also did not have my period. I did not feel like I was pregnant”* [El]; *“You are pregnant but you do not know if you really are. You do not know what you feel. You had such a long period of thinking what did I feel”* [Mar]; *“I did not feel anything. I did not know what to feel”* [Fos]; *“The only thing you think of is, how do I feel now?”* [Dus].

The Bodies. The Assemblages. The Figurations

The Importance for the IVF Debate

The former description allows me to conclude that human in vitro fertilization definitively ‘qualifies’ as an assemblage. As I have presented, in vitro has been made possible due to desire(s) of different types. It consists of various elements that have an influence, interact, mingle with, infiltrate each other and sink into each other. Every element guarantees the existence of the other, and as such, none of the elements, constituting an assemblage is superior or inferior to the other. At the same time it is quite transparent that the female subject is fueled by desire. Furthermore, the female body, already filled in with various ‘former’ percepts and affects, is very prone to connections and alliances with its surrounding reality. The female body connects with everything that happens to occupy the body territory (i.e. medical staff, medical equipment and medicines), and always constitutes a part of some assemblage and constantly interacts with its elements. IVF qualifies as an assemblage, not only because it contains different elements (technique and its toolbox, medical staff and a female patient), not only because those elements interact with each other (a nurse touching and talking to a female patient, liquids traveling through a female body, the catheter with embryos ‘entering’ female patient eyes and

skin) but also because their interplay is conditioned and launched by desire and stands for the desiring-production (exploring the possibilities of having a child). The female body as such is certainly external. The body allows the 'outside' to get/become 'inside'. It takes its surroundings and it becomes those very surroundings (a needle-a laparoscope-a catheter). Human in vitro fertilization is an assemblage as it stands for a space filled in with various and different percepts constantly circulating among its constitutive elements. IVF is an assemblage that very easily turns into another one (IVF 'spreads in time and space') allowing even more percepts (a luminosity of the sun, a shape of a stork) to enter the scene. It is an assemblage, a plane of immanence as it "*implicates processes of deterritorialization*" (Stivale 2004). It is a space where female bodies become deterritorialized and transformed, become affected, experience non-human becomings, turn into zones of indetermination and indiscernibility, become a body without organs (a female body becoming a 'warm tone of a voice', a 'comforting touch', a 'needle-prickled-body', a 'getting-(?)-having-(?)-embryos-body', a 'touched-body', a 'lifted-up-body' or a female body 'enriched' with the new organs). What is more, the female body becomes affected every time an encounter with the percepts (a warm voice of a doctor, a comforting touch of a nurse, a prickle of a needle) takes place. The female body becomes affected in a unique/singular, specific for a particular female body way. The affects (a 'needle-prickled body', hate, a 'waiting-having-not-having-embryo(s)-body', happiness or anxiety), to put it simply, 'translate themselves' into forces/powers enabling certain affirmative actions, or as Deleuze would put it, "*production*" of the embodied female subjects (expressed aloud emotions, talking with friends or taking a 'sunny-rainy' walk). The body, its materiality 'equipped with' former percepts and affects causes the human to feel, makes it conscious, lays the basis for the processes of thinking and enables the experiencing of emotions. The body represents the foundation of the human subjectivity.

To see human in vitro fertilization as an assemblage, as a plane of immanence, and to recognize the incredible peculiarities of the human body definitively allow formulating more adequate assessment of/conceptualization of/approach to human in vitro fertilization technique and practice than those characteristic to the radical feminists. They can be more adequate since looking at IVF and the participating

bodies in the suggested way makes it possible to realize the very fine interactions that occur between technologies, medical doctors and the women/female bodies, where the latter certainly do not 'qualify' for the last in the hierarchy or the weakest in the chain. The assessment of IVF technique/practice can also be much more positive than those suggested by the radical feminists.

When human in vitro fertilization is seen as an assemblage that has been created due to various desires, when it becomes realized that the linkages and conjunctions between its elements are possible precisely because of desires in motion (desiring-production) then IVF technique and practice can be evaluated in a much more positive way. The presence of desire sheds brighter light over IVF technique/practice. This causes both the technique and practice to have much more in common with positivity, productivity and action than passivity and sublimation, or in other words abuse and control. To realize that all the elements of IVF assemblage are equal in status as one cannot do without the other, is to again be skeptical about the oppressive *per se* 'nature' of IVF technique and practice. Furthermore, to acknowledge that IVF stands for an assemblage that consists of various elements/fragments, which are "*of disparate status and substance: ideas, things-human, animate, and inanimate (...)*" (Grosz 1994:167) that get connected, is to realize that 'things' different in status and substance do not necessarily have to invade each other but can link to/with each other. Therefore, I conclude that those are the connections and linkages that occur when in vitro takes place and it is not the "artificial invasion" of the female body as the radical feminists see it. Rosi Braidotti in her book Transpositions (2006) emphasizes that "*Being environmentally bound and territorially based, an embodied entity feeds upon, incorporates and transforms its (natural, social, human, or technological) environment constantly. Being embodied in this high-tech ecological manner means being immersed in fields of constant flows and transformations. Not all of them are positive, of course, although in such a dynamic system this cannot be known or judged a priori*" (2006:41). Therefore, to comprehend that the interacting elements of an assemblage do implicate processes of deterritorialization and so the creation of a plane of immanence (where nothing stays the way it was before the encounter, where there are only flows and intensities) of unknown *a priori* outcomes, is to realize that none

of the elements has more power than the others. This is precisely because no one can say what may occur when the encounter takes place (i.e. the technique and its toolbox do not dominate the women/female body per definition as no one can say what will happen to the technology or to the woman/female body when the contact occurs and when various becomings are commenced). What is more, if one realizes that the produced affects can turn into affirmative actions and productions, then to talk about women as passive victims dominated and abused by vicious doctors and technology, and as being merely suppliers of genetic material, is incorrect. The technology and practice do not diminish women/female bodies' capabilities of action and interaction. On the contrary, they can significantly add to them. The women contacted and talked to doctors, issued their objections and loudly expressed their resistance to things they did not evaluate as proper and positive. Moreover, the affected body is a body equipped with a force that makes it possible for the embodied female subject to become the one who is not willing to lose her control (i.e. joking about technology, becoming a technology expert, forgetting and 'letting go'). Women in IVF practice remained active and, most of the time, in control. Furthermore, to acknowledge that the female body is an intrinsic part of IVF assemblage, that assemblage itself implies motion (interactions) and deterritorialization and that it is the female subject whose desires launch all the occurring connections, then to ascribe to IVF technique/practice controlling (i.e. the women's subordinated position and victimization, women losing control over reproduction) and alluring facets appears to be an exaggeration. Even if one can detect a doctor's appetite for control, realizing that the female subject is highly responsible for a creation and motion of an assemblage does not allow her to be seen as a passive marionette speechlessly opting for and participating in IVF technique/practice. Moreover, to perceive IVF as an assemblage that can 'partly' turn into/become another one, is to comprehend that even if practice and technique can, in a sense, dominate women's lives, other elements/percepts (i.e. friends, relatives, sun or passed by landscapes) still matter and reduce the impact of IVF technique/practice. To see IVF as an assemblage consisting of many different elements ("flows of disparate status and substance") that can still interact together, to see the female body as prone to connections and alliances, to acknowledge that the female body is external, perceptive, affective and constantly becoming is to again

object to the radical feminists' statement that IVF technology stands for the "artificial invasion" of the female body. Technology does not reduce or dismember the woman/female body either. It is the female body that captures and embraces technology allowing it to become a part/a fragment of the body. Technology in this sense has more to do with an element of the body, the percept that the body registers/captures/senses/takes in. Thus the affect itself and not an alien and separate from the body dangerous machinery. When the female body is seen as affected, prone to deterritorialization (that has nothing to do with dismembering and reduction) and transformations, keen on nonhuman becomings, familiar with zones of indetermination, then technology can be seen as dissolving into the bodily-material reality. Furthermore, the technique does not seem to be that different from the other elements of the surrounding the body world that equally become turned into the body-material. In this sense, even when egg cells are aspirated and embryos are created 'outside' the body, the shape and the touch of catheter with embryos make them all (egg cells and embryos) immediately in the possession of the body. The affects caused by the technique and practice do not allow the women/female bodies to ever become reduced or dismembered. The external and affected bodies know nothing about reduction and dismembering. What surrounds the body, is captured by it, thus reduction or dismembering is in fact never at stake. I also cannot agree that technology, in general, stands for a source of various negative emotional hardships such as fear and grief. If one realizes that everything is dependent on the body's (that is filled in with various 'previous' percepts and affects and enables the human to be conscious, psychic and emotional) interactions with and selection of percepts (i.e. information that embryos may/may not transform into babies or the touch of the catheter with embryos) and selection of affects, then it becomes obvious that it is precisely because of this unique/singular body's interactions with and selection of variety of percepts and selection of affects that the final affect can be described as negative or positive affect-emotion (where the first indicate a decrease and the second an increase of the forces empowering one to act and relate with others). But again nothing can be anticipated *a priori*. Furthermore, if one sees that an IVF assemblage can turn into another one, that the body can be affected by billions of percepts coming from different elements of an assemblage then one can never be sure what will have a bigger impact on the body: an injected drug or a stork walking

along the road. In this sense, IVF technique and practice, again, cannot be evaluated as absolutely dominating women's lives. The technique and practice are present but so are the other elements, which do not allow the technique and practice to totally take over. At the same time, to recognize that the female body is singular/unique in its becomings, is to comprehend that no one becomes and no one becomes affected precisely in the same way. The technology and practice (i.e. behavior of medical staff) affects bodies differently. What is more, as I have already emphasized, sometimes a stork can affect the body more than egg cells aspiration. Thus, again IVF technique/practice should not be evaluated as absolutely dominating and abusive and oppressive to everybody, everywhere. In addition, the comprehension that to be affected means to be equipped with possibilities of affirmative and creative actions and productions allows seeing IVF technology and practice from a different perspective. To realize that the produced affects, which are pure intensities, can turn into actions/productions, is to comprehend that to define fear or grief *a priori* as always negative (decrease in one's forces to act and relate to others) indicates the cultural mediation. The grief, hate, fear or sadness as well as happiness, hope, euphoria or love all lead to various actions/productions (i.e. the becoming fear had its outcome in audibly expressed opinions, the becoming grief/sadness resulted in talking to friends/relatives, the becoming hope resulted in the continuation of the procedure). In this sense, I can say that in vitro does not have its outcome in negative emotional hardships. To say so means to allow cultural mediation and judgment to enter the debate. Eventually, to comprehend that the female body is prone to dismantling processes (that have nothing to do with dismembering) and can get the status of the body without organs, once more is to oppose the radical feminists' statement that IVF technique stands for the "artificial invasion" of the female bodies and that it dismembers and separates the woman/female body from the naturalness of conception. The interaction of the assemblage's elements indicates deterritorialization (things dissolving into one another, constantly changing and transforming their 'nature' i.e. technique [aspiration needle, plastic catheter] and doctor [operating aspiration needle, plastic catheter] do transform into new parts of the body, new reproductive organs). The female body is 'organ-less' as it gets 'enriched' with and/or 'grows' the new organs. IVF technique thus does not seem to invade and dismember the woman/female body as the technology becomes a part of

the body, a new, fresh and very useful organ. Furthermore, to see the female body as the 'organ-less' is to see it as a body whose other organs (i.e. eyes and ears) become 'in charge' (in case in charge' of reproduction'). If one argues that IVF technique results in anxieties and separates the woman/female body from the naturalness of conception, I would argue differently. I would say that it is precisely because new organs become in charge (i.e. eyes and ears thus conception becomes an overt phenomenon) that one may have an impression that the anxiety is intrinsic to in vitro and that the naturalness of conception is out of scene. Yet, it is not a technique that may give the sensations of anxiety and separateness from the naturalness of conception but rather the new organs that make the embodied subject fully aware and conscious of what is going on. At the same time, to comprehend that the processes of deterritorialization do take place, that the elements (i.e. technique, sun or stork) of the assemblage become the parts of the body, that the body constantly experiences nonhuman becomings, is to realize that the female body is a space where inhumanities dwell and circulate endlessly. The technology, but also the 'nature', both stand, after all, for the inhuman elements thus at the end of the day the body is basically filled in with nothing more than inhumanities. If technology and nature get equally transformed into inhumanities, can one then tell the difference between those two? When one looks into the spaces of the body spotting circulating inhumanities, can one distinguish between what was 'natural' and what wasn't anymore? And after all, is it really that necessary to want to know and eventually to know? If the female body constantly experiences nonhuman becomings and stands for a 'space' familiar with inhumanities of various 'types', then is one right to say that technology is responsible for the dehumanization and the "artificial invasion"? It seems that the woman/female body has actually been affirmatively inhuman for a pretty long time. *"In truth, there are only inhumanities, human are made exclusively of inhumanities, but very different ones, of very different natures and speeds"* (Deleuze, 190 [50]).

With IVF seen as an assemblage and a plane of immanence, but also with the peculiarities of the human body recognized, more positive approach to in vitro can be suggested. I will always oppose the radical feminists' idea that new reproductive techniques should not be approved. IVF when perceived as an assemblage and the female body as equipped with the discussed 'abilities' enable realization that

everything, everywhere always remains in motion and that there is no stillness when it comes to the issues of life. The ceaseless motion metamorphoses, and becomings do allow comprehending that nothing is *a priori* foreseen and planned. In this sense I can say that the technology can be less important than a stork or it can create sensations followed by the affirmative human actions. Therefore, not to approve technology is to close the doors to the possible enhancement and empowerment of the woman/female body. It means, in fact, to control and freeze the motion. Thus, it would be much better to let the motion take place. Nothing, can be *a priori* foreseen and anticipated. However, if the elements of IVF assemblage and circulating percepts (i.e. doctors, their behavior and what they do with technologies) are nicely ‘shaped’ from the start then it is possible to ‘imagine’ that the outcomes (affects) may at least be the most optimal ones and all about the increase of one’s forces/powers to act and relate with others. “(...) *it is the degree and speed of the affects that determines the power (potentia) of a body and consequently also the level of interactivity with other entities*” (Braidotti 2000:136). Thus, should not one try to increase and speed up the possibilities of positive becomings and encounters with others?

With the proposed ways of seeing in vitro and the human body, the concepts of IVF technique and practice can become more positively charged. The technology and its practice do not have to appear as ‘solid blocks’ standing in opposition to the woman/female body. They (technology and practice) can be seen as divided into billions of almost imperceptible fragments, bits, pieces and percepts differently registered and captured by the female bodies. They can be perceived as the sources of the affected bodies’ forces. Furthermore, they can also be seen as turned into the very women/female body’s parts and the very women/female body’s affects thus respectively women/female body’s parts and affects themselves. Claire Colebrook writes, “*We immerse ourselves in the flow of life’s perceptions. The human becomes more than itself, or expands to its highest power, not by affirming its humanity, nor by returning to animal state, but by becoming-hybrid with what is not itself*” (Colebrook 2002:129)

SECTION I.II

Zoe and Natal Power

As Braidotti stresses in *Transpositions* (2006) “*zoe*” is “(...) *the generative vitality of non- or pre-human or animal life*”; “(...) *the mindless vitality of Life carrying on independently of and regardless of rational control*” (2006:37). I want to apply Braidotti’s understanding of *zoe* to the body material, that is to all the operating/living lives of their own cells, tissues and organs; to the life of veins, neurons and chemical substances circulating, connecting, transforming, fueling and maintaining the very existence of the human body. It is the kind of life that is taken for granted and is usually not noticed. It is the kind of life that goes on or not independent of the embodied subject’s ‘rational wishes’. It is the kind of life that can never be fully understood, comprehended or controlled though efforts might be taken in order to monitor or improve/support it. The ‘tangible presence’ of *zoe* can be easily detected in every interviewed female body who entered the territories of contemporary medicine. The problems with conception, the inability to understand the reasons for which fertilization and conception of a child could not take place, the slow growth of egg cells and their small overall number despite injected hormones, the small number of embryos created from the high number of egg cells, the inability of embryos to turn into fetuses, the miscarriages that occurred after positive pregnancy tests and the unexpected reactions such as increased/decreased blood pressure, gaining weight in a very short period, internal bleedings, infections all those signalize and indicate the ‘presence’ of *zoe*. Furthermore, *zoe* is a generative power and force, life that is creative, productive and continuous. Natality is essential as it precisely charges the notion of human life with creativity, production and action, and not destruction and decay. The ‘*zoe*-body’ equipped with natal power has the potential to prolong itself, to produce, to generate and begin this very life. I want to say that the continuity of life can be very much observed in the fertility clinics. To generate and create life, to actualize the natal potency/power was the aim of every woman, I talked to, who entered the fertility clinic. The ‘*zoe*-body’ equipped with natal power has a potential to generate and commence life. I say potential because, to put it simply, the prolongation and generation of life and the natal power do not always have to be actualized. It may happen but not necessarily. Every woman I talked to, was not very satisfied with her generative/natal powers. It was a real

challenge to produce life when participating in certain medical protocols such as IVF. The application of in vitro was not always successful. It happened many times that there was no pregnancy after the embryo transfer or the transfer was later on followed by the miscarriage.

Zoe and Natal Power

The Importance for the IVF Debate

The female body is a 'zoe-body'. Such comprehension allows more accurate evaluation and conceptualization of, but also approach to, IVF technique/practice as it enables recognition of the body's capacities and capabilities. It also allows more positive assessment/conceptualization/approach to be suggested. With the awareness that the body is a 'zoe-body', then it can be argued that nothing but literally nothing can fully monitor or control the body and for that matter the reproduction. It can be semi-control but not a control that is always totally exercised. The 'zoe-body' is unpredictable; it is a labyrinth full of mysteries and unexpected 'actions'. It truly has the 'life' of its own that can do both: either cooperate with or, on the contrary escape from any form of planned/unplanned interventions with no explanations. *"This obscenity, this life in me, is intrinsic to my being and yet so much 'itself', that it is independent of the will, the demands and expectations of the sovereign consciousness. This zoe makes me tick and yet escapes the control of the supervisory agency of the Self-built on the twin pillars of narcissism and paranoia. Zoe carries on relentlessly and is cats out of the holy precinct of the 'me' that demands control and fails to obtain it (...)"* (Braidotti 2002:133). Therefore, to assess IVF technique and practice as superior to the body and taking the body and the reproduction under full control is not right. To comprehend that *zoe* is a generative power, life that simply goes on, to understand that the human life is about production and continuity, and to realize that the female body is able to generate and begin life and to actualize her natal potency/power, is not to assess in vitro as alluring and imposing the notions of obligatory motherhood. On the contrary, IVF can be evaluated as an enzyme, a catalyst of life's productivity and continuity when, for whatever reasons, the productivity gets impaired. In my opinion, IVF can be evaluated as the procedure that 'recognizes' the female power and potency to generate life and enables (if possible) its actualization. Furthermore, to recognize that the female body is a 'zoe-

body' that has a potential to generate life, which does not have to be actualized, is to not only see IVF as a possible enzyme, but also (and again) as not taking the female body and reproduction under absolute control. Therefore, the proposition of a non-approval of human in vitro fertilization because it is superior and controlling, alluring and imposing the notions of obligatory motherhood, does not appear to be correct either. Knowing that *zoe* can sometimes be 'cooperative' and that it stands for a generative power it would be much better to conceptualize IVF as the mentioned catalyst and a type of a medical help, and then allow it to occur as it could offer true relief to many women facing fertility problems.

SECTION I.III

Pregnancy, Post Partum, Percepts and Affects

To do the pregnancy test for every woman was to become a very powerful affect of the 'possibly-becoming-of-having-a-child-body'. *"I did a test and I found out that I was pregnant. We could not believe that"* [Bian]; *"I could not believe that I was pregnant. I did the test again after two days"* [Bo]; *"I bought the test. I waited because I did not dare to do the test. I thought I would wait a little bit longer for surety (...) Seeing the pregnancy test you almost cannot believe it. You start crying. Emotions are bigger than you"* [Ane]. However, even when test was positive, most of the time it was not taken as solid assurance that there would be a baby after nine months. Sometimes, of course, the test was enough for the becoming the 'having-a-baby-body', the affect of hope and happiness. *"It was happiness, happiness"* [Ane]; *"I did a test. We did two tests. I kept the test. I felt that I was pregnant"* [Fos]. Yet, if there had been many unsuccessful years spent on trying to become pregnant or if there had already been a miscarriage(s) the becoming the 'having-a-child-body', the affect of happiness could not easily take place, even if the symptoms were easy to 'read'. For some it was the percept of the blurring of the ultrasound monitor and/or the sound of the child's heart beat which triggered (though not always one hundred percent) or definitely terminated their becoming the 'having-a-baby-body'. *"Ultrasound was a confirmation"* [Bian]; *"Ultrasound. Little hand, and it was waving. It was like the baby was saying everything was ok then I got the feeling that maybe everything was going to be ok"* [Dus]; *"I did not believe the pregnancy test. It was an ultrasound that convinced me that I would have a child"* [Ter]; *"When I saw*

I felt/knew I succeeded” [Bea]; *“Ultrasound was a confirmation for me and made me peaceful”* [Viol]; *“The first heart beat. I was unable to say anything. I so wanted to cry”* [Mon]; *“At the ultrasound. I still see the face [woman doing ultrasound scans]. She checked again and again. I cannot find the heart, she said. (...) It was pain and it was sadness”* [Ane]; *“I thought I was going to be happy. Then I heard that the pregnancy was not developing. I started to cry”* [Ewsi]. For some other women, neither test nor ultrasound worked but only the very movement of the child. For some it was the changing shape of their bodies that resulted in their becoming the ‘having-a-child-body’. However, many times the ‘possibly-not-having-a-child-body’ becoming prevailed and many women were very careful to start believing that the child would one day be born. *“You are careful (...) because many things can still go wrong”* [Mia]; *“We were very careful. We postponed the happiness”* [Bian]; *“I again was pregnant. I was very scared. Only my sister knew. My parents only had an idea that I was pregnant”* [Ane]; *“I was afraid that something would go wrong”* [El]; *“Will we manage to come to terms?”* [Bo]; *“I was in disbelief (...) I did not have the feeling it [a child] was inside me. Do not be so excited yet. It still can go wrong. (...) Try to stay normal and see what happens (...) I do not want to hope too much because if it went wrong, then it would be much tougher. It would be tough anyhow but just for yourself (...) I did not dare to be happy because in case it went wrong”* [Dus]. Usually, it was not until the child was born that the women eventually felt that they did become the ‘having-a-child-body’ and finally believed in their success and experienced joy. *“I was sure I was not pregnant. (...) Do not be too happy about it – I told myself. Movement [of a child] was the sign that it was ok. To see her [a child], to have her in my arms was it. I cried my eyes out. I was happy”* [Mari]; *“When he was born I finally felt it was ok. Now it was ok. He was there, I felt it was ok. Then I was ok”* [Dus]. Even if to become the ‘having-a-child-body’, the affect of happiness was not easily reached, the whole period of pregnancy allowed forgetting about IVF technique and practice. That was because some elements characteristic for human in vitro fertilization (i.e. technique and its toolbox) definitively went out of ‘sight’. As such, certain percepts intrinsic to in vitro could no longer enter the female bodies. *“When I was pregnant I did not think about IVF”* [El]; *“I loved me being pregnant. I enjoyed it so much”* [Fos] Furthermore, the visibility of pregnancy and the becomings/affects (i.e. growing abdomen; morning

sickness; hunger; tiredness) that accompanied pregnancy stood for the becoming the one of the 'many-pregnant-bod(ies)y'. The strongest affects followed the birth and the presence of a new born child. The moment a child was born, seen, touched and hugged overshadowed other percepts and especially those linked to the human in vitro fertilization procedure. *"You just feel happiness"* [Ane]; *"Success, the child makes you forget everything"* [Bo]; *"With the child born you forget. Time is passing, the child is there, so you forget"* [Fos]; *"When my daughter was born (...) when I brought her home and sat with her I was crying from happiness (...) The two years of my child's life is the best reward"* [Mon]. It is also interesting to mention that for the Polish women, contrary to the Dutch, the time they were pregnant was more negatively charged. It was because IVF technique and practice, as condemned and rejected by the Vatican and the Polish Catholic Church with all the following it consequences (see Chapter Three and Four), did not evoke sympathetic responses and social attitudes. As a result, during the pregnancy the Polish female participants tried to be very careful not to mention that the conception was a result of the IVF procedure. Everything that could indicated that in vitro was involved, they tried to erase. Justy and her husband are involved in the Catholic Church's activities thus they gave the photos of the embryos to her mother. *"If someone saw them we could be in real troubles (...) We do not want to be attacked. We do not want to be told that we live in sin."*

Pregnancy, Post Partum, Percepts and Affects

The Importance for the IVF Debate

Not to ignore the fact that the pregnancy and the post partum period may follow IVF but also to realize that the female body is 'crowded with' affects allow proposition of more adequate assessment and conceptualization of but also approach to in vitro technique/practice. The evaluation/conceptualization/approach can be more accurate because they highlight the women/female bodies' interactions with their surrounding. At the same time, to comprehend that IVF is an assemblage that can become another one may also result in more adequate evaluation/conceptualization/approach. This is because it enables the comprehension that life is not about stillness and petrification, but about movement and metamorphoses.

Furthermore, the evaluation may also be much more positively charged. The pregnancy and the post partum period both stand for the time when certain elements and percepts intrinsic to the IVF assemblage (i.e. technique and its toolbox, doctors performing IVF) vanish from the women's lives. When pregnancy occurs and a child appears, the female body no longer constitutes a part of the IVF assemblage. To include the pregnancy and the post partum period is then to realize that to attribute total control of the women's lives and reproduction to IVF technique/practice is not entirely true. The same can be concluded when IVF is seen as an assemblage that is not enclosed in firm borders, but is prone to transformations and eventual disappearance. With the comprehension that in vitro can 'melt away' from the women's lives, it becomes possible to assess IVF as merely a tool that is used by the women in order to achieve their goals. In this sense, the radical feminists' rhetoric about passive, victimized, abused and oppressed women must be objected to. Furthermore, not to ignore the pregnancy period and to realize that the female body can be affected in many different ways, is to be able to oppose the radical feminists' statement that in vitro is superior to and stands for the "artificial invasion" of the female body and that it takes the control over reproduction out of women's hands. The point is that the pregnancy stands for the period when the female body, in response to the percept of the tactile and visible embryo transfer, enables sensations/becomings/affects (i.e. morning sickness, tender breasts, tiredness) that are easily recognized and interpreted as typical/characteristic for the pregnancy. It is also the female body that enables the growth and delivery of a child, "(...) *the mother still nurtures the foetus through her body and gives birth to it in the traditional way*" (Stanworth 1987:28). The body is external, affected, filled in with 'former' percepts and affects, 'crowded' with inhumanities and technology is becoming part of the body or the very bodily-material percept and affect. However, at the same time, the body is the 'zoe-body' and never 'gets rid of' its own 'capabilities'. In this sense, to speak about a technological "invasion" of the body, its superiority towards the body, control over the body and the reproduction does not seem to be all together correct. Not to leave out the pregnancy and the post partum period, to comprehend that IVF is an assemblage which can 'entirely' turn into another one, to realize that the female body can be differently affected, to understand that affects can lead to affirmative actions/productions is also to be able to object to

the radical feminists' rhetoric that in vitro always stands for a source of negative emotional hardships such as fear, grief or sadness. I am not trying to say that IVF technique and practice are easy and pleasurable and do not add to tensions, worries and nervousness. What I am trying to argue is that the female body is exposed to many percepts and 'crowded with' many affects that come from many elements of incessantly changing assemblages, of which the female body is a part. Therefore, I would say that it is mostly up to the new assemblages full of different percepts, the unique/singular body's selection and interaction with them, but also selection of produced affects, than up to the fact that the pregnancy resulted from IVF that negativity (decrease of one's power to act) can appear. Yet, it is absolutely crucial to remember that to say that anxiety, fear or grief are nothing but negative, is precisely the effect of cultural mediation. As what we call positive affects/emotions (i.e. joy) and what we describe as negative ones (i.e. grief) can both be transformed into the affirmative, powerful (*potentia*) and creative actions of the embodied subjects. Therefore, to talk about IVF as a negative-hardships-emotions-affects trigger is, I would say, a culturally marked assessment.

With the proposed ways of discussing human in vitro fertilization, the approach to the technique/practice can also be more positive than the one proposed by the radical feminists. Not to ignore the pregnancy and the post partum period, to realize that IVF is an assemblage that can turn into another one, to comprehend the peculiarities of the body allows conclusion that it is not a good idea to not approve IVF technique and practice. To realize that it is the female body that enables the growth and birth of a child and to realize that IVF is just one of the many assemblages the female body is a part of, is to approach in vitro as one of many events the human body participates in. Saying this I do not want to diminish the 'weight' of IVF technique and practice and compare it to a pleasurable dinner with friends. Knowing, however, that it cannot be *a priori* anticipated how the body can be affected I would rather suggest to not demonize IVF, but to approach it as an event, as a space visited by the female body and, most importantly, as a space of the most convenient 'shapes'. This is because even if the final affects cannot be forecasted it can still be expected that with the convenient 'shapes' (well-organized technique/practice) they (the produced affects) will become the most optimal ones.

Also, with the proposed ways of debating in vitro also more positive concepts of IVF technique and practice can be suggested. Human in vitro fertilization does not have to be conceptualized as controlling, dominating, oppressive, superior and as an “artificial invasion”. Rather, it can be defined as a tool, thanks to which women can possibly achieve their goals. It can be a tool that is used and put aside if no longer needed, one of many events women decide to become a part of, a percept and an affect. An affect, which is not necessarily all about negativity but more about affirmative actions. A percept that can completely lose its force of impact and not be able to affect anymore. “*You forget about it*” [Dus]; “*You forget everything*” [Ane]; “*I simply forgot all about it*” [Lid].

SECTION II

The Women/Female Bodies and Men/Male Bodies and Children Bodies and IVF Technique/Practice

In a Polemic with the Vatican

To briefly repeat from the previous Sections, the always desiring assemblage gathers various elements in its fluid embrace. Yet, it does not mind enriching the ‘old’ elements with the ‘new’ ones or even completely replacing and converting its ‘content’ (i.e. the pregnancy and the post partum period following the in vitro period). An assemblage always implicates movement and as such transformation, becoming, deterritorialization and dismantling. There is a constant motion within an assemblage and there is no such thing as a ‘full stop’. The elements of the assemblage remain in endless interactions, undergoing metamorphoses whose results cannot be easily anticipated. The percepts circulate with an amazing fierceness and persistence triggering becomings of various shapes and of the frequently unpredictable forms. There is no surety which elements/percepts and, if any at all, would have an impact on the others (and honestly which (?) others). It cannot be said what kind of impact would be at stake or if there actually would be an impact at all. If it happens that the desiring human elements find themselves within the assemblage, they participate in everything that an assemblage offers. The body of the human being is a ‘zoe-body’ equipped with natal power. It facilitates sensations and perception, makes the human conscious, remembering, psychic, emotional; it forms

the basis of the human's subjectivity and is very keen on trying what an assemblage has on its menu. The becomings and deterritorialization implicated by an assemblage are welcomed by the rich in percepts and affects as 'present' as 'saved-and-stored' in the bodily 'memory-banks', desiring, connective, external, affective, singular bodies familiar with becomings, deterritorializations, transformations and dismantling processes.

As I have argued before, in vitro fertilization can take place because of various, equally important desires in motion (i.e. understanding of the working of the human reproductive system, researching for the ways of creating embryos outside the body and exploring possibilities of having a child). Undoubtedly, the desiring couples, female and male participants are highly responsible for the fact that in vitro may actually happen. At the same time, it is the desiring couple who makes in vitro to occur indeed. Desires of couples having conceptive difficulties, when exploring the landscapes of contemporary medicine, make their bodies to 'open up' and enable their connectivity simultaneously setting everything into motion. They, women and men, connect with technology and doctors, and at the same time, doctors start connecting with technology as well as female and male participants. The technique, doctors and participating couples mutually guarantee each other existence and one cannot do without the other. The technology, doctors and couples are not tightly glued together. The female and male participants constantly change landscapes. They exist in clinics, work in homes or offices, walk in parks and on the streets, travel, visit friends, dwell in domestic dimensions and go back to the medical centers again. They are exposed to billions of various elements and percepts of the 'reality' surrounding them. They meet and talk with colleagues, friends and relatives. They go shopping, read books, watch television, drink coffee or eat dinner. They feel the warmth of the sun or the change in humidity of rainy days. There is an abundance of life in IVF couples' lives. The technology, doctors and couples are also not eternally shackled together. There is always a moment when couples enter completely new territories where the in vitro doctor-elements or in vitro technology-elements are no longer visible-audible-gustatory-olfactory-tactile. The pregnancy and the post partum period certainly 'qualify' for those new territories without the visible-audible-gustatory-olfactory-tactile presence of the elements and percepts characteristic for in

vitro. The technique, doctors, various landscapes, participating women and men and countless percepts form the net of connections and linkages though it cannot be *a priori* said what/who will affect what/who (i.e. doctor/technique/various landscapes having an impact on female and male participants; a couple, female and male participants influencing doctor/technique/various landscapes). At the same time, it cannot be anticipated how the female or the male body will become affected, what types of becomings will take place and what will actually happen if certain fusions and conjunctions occur (i.e. is it going to be an affect of joy or sadness, is it going to be a becoming the 'having' or maybe the 'not-having-embryos-body'). Furthermore, the human body is the 'zoe-body' always surprising, not really fully comprehended (at least at present), very keen on keeping its secrets unrevealed and full of generative forces, natal potency/power, which can be actualized. The female and male bodies always remain connective. They connect with everything that populates their landscapes. The moment the encounters take place, the female and male bodies become external. The female and male external bodies are able to capture their surroundings. Everything can be absorbed by the external bodies, the needles and the scans, the voice of the doctor, the touch of the nurse, the warmth of the sun and the chilly wind's blows. The bodies are about sensing and perceiving; they are familiar with consciousness and definitively befriended with emotions. Every encounter affects bodies in unique and not easily predictable ways. Every encounter is always followed by various becomings, deterritorializations and dismantlings. A becoming a needle, a doctor's voice, a 'having-not-having-embryos-body', an affect of joy, happiness, pain, disappointment, trust, peace or tranquility.

SECTION III

Landscapes of the Finest Selection of Difference II

The Becoming of Multitude, of 'One-Another'

If one wants to see 'reality' as consisting of fragments which remain enclosed within their frames and stay impenetrable, one can see it this way. Yet, if such a path is chosen, the rainbow colors of the unpredictable and unexpected kaleidoscopic figurations may easily go unnoticed. That would certainly be a pity. The 'in-between-within-female-male-bodies-spaces' when in a 'face/body-to-face/body-tango' might be full of kaleidoscopic-rainbows. There could be body-connections, transformations and the sensations/expressions of love at stake. Some may sense

‘old-romance-like-shadows’ but it seems to me that it could be an entirely ‘new version of a romance’. I will try to prove this as to come with more accurate and positive assessment of, concept of and approach to human in vitro fertilization.

The Female, Male and Children Bodies and Assemblages

I have already emphasized that the elements/percepts in vitro consist of remain in a constant motion and countless interactions are taking place. The technique and the doctors occupy the same territory the female bodies do for a relatively long time. Even if things do not happen in the clinics still their presence remains. The technology, its toolbox and doctors connect with and affect the female bodies. In the former Section I have already pointed out how the female body may become and how it can get affected. The female bodies underwent various becomings and many affects entered and were produced in their corporeal dimensions. They became a needle, an injected liquid, an ultrasound probe, a warm doctor’s voice, a comforting nurse’s touch, a ‘touched-body’, a ‘spoken-to-body’, a ‘needle-prickled-body’, a ‘having-not-having-embryos-body’, a ‘spoken-to-having-embryo(s)-body’ or a ‘getting-(?)-having-(?)-embryos-body’. They became the affects of suffering, frustration, disgust, sadness, doubt, happiness, hatred, love, acceptance, gratitude, grief, horror or hope. When some of the elements characteristic to in vitro (i.e. the technology and doctors) vanished from the couples’ lives, thus when the pregnancy and the post partum period started, stubborn and persistent becomings certainly went on and on (i.e. the ‘having-a-child-body’). However, there were not only female bodies interacting with the in vitro elements or going through the pregnancy and the post partum. The male partners also became familiar with the medical landscapes of IVF technique and practice and were present during the pregnancy and the post partum period.

The human being is driven by desires that are all about linkages and alliances. Those desires are also absolutely essential for the existence of an assemblage and the motion within it. When discussing in vitro with the Dutch couples, it turned out that every step intrinsic to in vitro procedure was taken together as a team. Furthermore, the women and the men were both engaged in the pregnancy and the post partum period. When it comes to the Polish couples, in vitro was also teamwork and so was

the pregnancy and the post partum period. The Dutch and the Polish couples always tried to visit doctors, to do ultrasound scans of the stimulated ovaries, egg cells' aspiration and embryo transfer together. But, sometimes it was not feasible. In most of the cases both partners had a job. For the women to be at the clinic was, of course, indisputable. Therefore, it was a 'must' for them to take a day or couples of hours off to do so. However, the men did not have to be in the medical centers as frequently as the women had to and so sometimes they did not accompany their partners. In the case of the Dutch couples the men's not-attendance, though it almost never happened, had basically to do with their particular job obligations. The situation was more complicated as far as the Polish couples were concerned. Because of how infertility and IVF are perceived and approached in the Polish society (see also Chapter Three and Four) the men did not want to mention their participation in this medical procedure. To come with different excuses every time their female partners went to the clinic was not always possible. As a result, there were moments when the Polish women had to face doctors and technology all by themselves. Yet, both in the Netherlands and in Poland, the majority of the couples on the quest for a child did enter the 'medical-lands' together. *"My husband was with me non-stop. I never went alone. He was always with me. (...) I felt supported by him. It was good"* [Mari]; *"My husband was with me all the time"* [Mia]; *"We were together. Teamwork. Emotional support. He was always there"* [Bian]; *"He went with me to the hospital. We were both doing it"* [Syla]; *"Teamwork. Always together. Always with me. I did not feel that I was alone"* [Jus]; *"It was teamwork. When he could, he went together with me. I counted on him"* [El]; *"I went with her every time. It was mutual help"* [Tru's male partner]; *"With my partner we were always together. He attended all tests and examinations. It was teamwork. Support"* [Mar]; *"We were working together. Mutual support"* [Mui]; *"Working together. I never felt alone. He always went with me. We always went together. He was supporting me all the time"* [Fos]; *"It was teamwork. He became my support"* [Pau]; *"We were a team. We helped each other. We were always coming to the clinic together"* [Mag]; *"It was teamwork"* [Viol]; *"We were always together, constantly together"* [Ali]. The Polish and the Dutch women and men on the quest for a child were both involved in the pregnancy and the post partum period playing in a team-like spirit. A pregnancy test, needed check-ups and visits to doctors but also the birth of a child was, again, done together.

The changing assemblages always stand for the spaces filled in with circulating percepts and their elements follow the assemblages' logic of becomings and affections. The male body 'walking through' the choppy landscapes of in vitro also experienced various becomings and got filled in with many different affects. The males' becomings were certainly different when compared to the women participants. This was not only because every body becomes and gets affected in a singular/unique/distinct way, but also because the male body's interactions, especially with technology and its toolbox, were of a different 'nature'. The interactions/connections between the technique with its 'implements' and the male body were usually limited to the visible-audible-olfactory percepts whereas the female bodies embraced also the gustatory-tactile ones. The male bodies became a 'liquid-injections-seen-body', an 'ultrasound-probe-seen-body', an 'aspiration-needle-seen-body', an 'embryo-catheter-transfer-seen-body', a 'having-not-having-embryos-body' (when waiting for the fertilization's results), a 'getting-(?)-having-(?)-embryos-body' (when seeing the embryo transfer). Those becomings were the becomings plenitude of various affections. The male bodies got familiar with the becoming frustration, happiness, hope, sadness, acceptance, gratitude, grief or horror. Going through pregnancy and the post partum period, the male bodies equally went on with different transformations and affections. They became, to count only few, a 'positive-negative-pregnancy-test-seen-body', a 'blur-of-the-ultrasound-body', a 'heart-beat-no-beat-ultrasound-body', a 'heaving-a-child-body', and/or a 'new-born-present-seen-heard-touched-baby-body'.

The Female, Male and Children Bodies and Assemblages

In the Clinics and Beyond

Pregnancy and Post Partum Period

The endlessly transforming assemblages consist of many elements. All those elements gathered together can interact and various percepts may trigger different metamorphoses. The human body becomes and it becomes affected. Furthermore, the affects that get produced due to different encounters enable creativity and ability thus *summa summarum* make it possible for the embodied subjects to commence different actions. Being affected, being 'ready' for an action, acting, being desire driven and

being a part of an assemblage, full of affects, means to be all about connections, means to be in constant movement, means to be a movement. It is never ending process. It is unceasing motion where directions and outcomes cannot be easily determined or predicted. It is motion itself, where the beginning cannot really be mapped out and where no one can actually see the end. It is a 'not-a-chain-but-rhizomatic-reaction', growing and spreading at its own speed and into every direction like ivy. The moment bodies produce linkages and get affected, their externality and singularity come into play causing affections, metamorphoses, nonhuman becomings, deterritorializations and dismantlings to immediately take place. At the same time, the body is filled in with the 'former' percepts and affects and is the basis, the facilitator of human sensations and perception as well as consciousness, memory, emotions and mental processes.

When IVF was taking place, the doctors, the technique, the female and male bodies did not remain indifferent towards each other. Almost every Dutch woman, unlike the Polish ones, evaluated the aspiration of egg cells negatively. This was because, for the Dutch, it was a very painful medical procedure as it was done without anesthesia. The aspiration was always done together, in a female-male team. Therefore, the story of one Dutch woman, Mia, is a story I heard from many Dutch women. Driven by desire (where the object of desire was a child) while undergoing aspiration Mia was becoming the affect of grief. Mia's partner, driven by the same desire, seeing/witnessing the whole procedure was also becoming the affect of frustration and grief. Yet, he was also seeing-hearing what Mia was going through. This moment of seeing-hearing was the moment of commenced connections, the moment of getting into a tango of bilateral linkages that left 'no-body' unchanged and unaffected. It was the moment of becoming external, of becoming and of getting affected. Mia's partner was becoming Mia, he was becoming the 'Mia's-body-seen-in-pain', the affect of empathy and grief. Mia and her partner were affected differently and by different affects, crowded together in a doctor's cabinet, driven by the desire of easing the pain, got ready for an action and grabbed each other hands in a tight and inseparable clasp. And again, the moment of 'grabbing' was the moment of connecting, of becoming external, of becoming and of getting affected. The sensed/perceived tactile warmth of her partner's arm's skin was Mia's becoming 'her

partner', 'his arm', that 'warmth', the 'her-partner-squeezed-warm-arm-body', the affect of love that allowed her to go through the procedure. The sensed/perceived tactile warmth of Mia's hand's skin was Mia's partner's becoming 'Mia', 'her-squeeze', the 'Mia's-squeezing-warm-hand-body', the affect of compassion and empathy that allowed him to become useful and get intensively engaged in the IVF journey. The aspiration was, of course, not the only event the Dutch but also the Polish women participated in. The aspiration was preceded by ultrasound scans (done to measure the growth of the egg cells) and followed by the embryo transfer. There was sometimes a need to 'use' other, more unique tools from the technology's toolbox such as immunological injections prepared from human blood. Such necessity resulted in Viola's shots done on the basis of her husband's blood and as such her becoming the 'injected-floating-blood-body' and the 'her-partner-floating-blood-body', thus very significant becoming each other. Sylva and her partner also underwent various becoming and were affected in many different ways when in IVF. Because of the produced affects of grief, happiness, loneliness, horror or gratitude, of Sylva's and her partner's desires (i.e. being a parent, easing the pain, becoming successful) but also their mutual presence in the clinic, Sylva was becoming 'her husband', 'his eyes' look' and the 'his-looking-eyes-body' during ultrasound scans. She became 'his hand' and the 'his-squeezed-hand-body' during embryo transfer. She became affected; she became the affects of hope and love. Her partner, on the other hand, underwent similar, though certainly distinct, transformations and deterritorializations when he became the affect of empathy which made him to try to undertake efforts to help his wife where and however he could. *"You cannot help (...) I tried to support my wife and help her in the house. I can cook, I can clean. I cannot feel what my wife is feeling. I tried to do my best"* [Sylva's partner]. Desiring and differently affected El was always with her partner. Therefore, times during scans, aspiration or transfer were the moments of El's becoming 'her partner', 'his looking eyes', the 'his-looking-body', the 'his-warm-comforting-voice-body' or the 'his-smile-body', the affect of love. El's partner had also his own becoming. He became 'El', the 'El's-eyes-body', the 'El's-painful-complain-body' or the 'El's-smiling-joking-body', the affects of love and empathy. Being affected in such way, El got very confident whereas her partner as she stressed *"(...) left decisions to me. He did not push me. He did not make decisions for me. He wanted to have a child but*

he was aware that the whole job must be done by me.” Similarly to El’s, Ane’s partner underwent various becomings and was differently affected. He remained supportive yet was never insistent or pushy. Ane explained, *“He [Ane’s partner] says I want what you want. You have to go through it all; you have to do it with your body. About IVF, he always says that he is doing this with me. When you say stop, we stop. Because I cannot decide for you (...) He always says you have to take the injections, you have to go to the hospital (...) Even if he wants children very much he says any moment you say it is enough, we stop.”* Mal’s partner’s becomings and affections also resulted in him being supportive but not domineering. *“He [Mal’s partner] agreed with every thing I decided to do.”* Becoming each other for Viol’s husband was to become aware of her dedication. Becoming and being affected in such a way, he was not only very supporting but also explicit about his minimal contribution to the whole process. *“He said that his share stood for ten percent of mine. (...) When I lost my first pregnancy, he said that the most important thing was that nothing bad had happened to me. He took everything very peacefully and everything he had to do was ‘normal’ for him. He was not with standing and he always tried to be available”* [Viol]. Becoming one another, becoming each other’s visible and audible pain and effort, each other’s visible and audible success and happiness, Tru and her partner were prepared to live without children if that had been necessary. *“We discussed whether we were going to be happy without a child, and the conclusion was yes, it would have been sadness and we would have cried, but we could have lived with it.”* Similarly to Tru and her partner, Mar’s and her partner’s becomings one another resulted in countless discussions. *“We always talked things over.”* What is more, Tru’s and her partner’s becomings allowed both of them to go through the whole procedure. *“We did it as a team; otherwise we could not have done it.”* It was also due to the becomings each other that Ter concluded *“I would not have gone through it all by myself.”* Yet, there were moments when the becoming one another, becoming each other’s complaints, tears, silence or shouts was the becoming sadness, anger or loneliness. Being affected in such way Dus and her partner had as she said *“difficulties of understanding each other.”* Those becomings and affections sometimes resulted in a situation where one partner, usually the men, found it hard to continue with the procedure and as such the women felt left alone in their quest. Mal admitted that *“Sometimes he had had enough. In*

those moments I felt I was all by myself.” Magg was also familiar with this situation. She emphasized that there were moments when her partner got very tired which resulted in his withdrawing, closure and silence. It also happened that interactions between technology and the female body resulted in her decision to quit. At a certain moment, Ewsi had enough. Ewsi’s complaints and tiredness were her partner’s becoming sadness and empathy. Affected in such way, as Ewsi said, he was crying that if only he could have possibly carried a child, he would have tried to go through the whole procedure instead of Ewsi.

Also, with the changing landscapes, IVF technique, doctors, female and male bodies did not remain separate and indifferent towards each other (i.e. hormonal injections, phone conversations with doctors, waiting for the results of fertilization, all those did not take place in the medical centers). The female’s becoming sadness when there were no embryos was the male’s becoming the ‘his-female-partner-sadness-body’. Those affections, proximity and desire (i.e. to comfort, to help, to ease the pain) triggered various connections and the female’s becoming the ‘her-partner-hugging-body’, the affect of hope and the male’s becoming the ‘his-partner-hugging-body’, the affect of hope. Due to this, they both had enough strength to overcome their loss and walk on. The female’s becoming happiness when the transfer could take place was the male’s becoming the ‘his-female-partner-happiness-body’. Affected positively, they linked, they became each other; each other’s smile, each other’s warm embrace and each other’s warmth. They became the affect of gratitude and love. Thus, they both not only remained optimistic, believing in their success but they also continued with the procedure. There were many becoming and affections launched by technology and doctors. Equally, there were many becoming one another, each other’s eyes, lips, smiles, tears, complains, euphoria and horror. The becoming each other’s warmth, squeezes, hugs, embraces, kisses, arms, hands, lips, audibly comforting voices and billions becoming/affects of love, empathy, fear, anger, disappointment, gratitude, grief, loneliness or happiness.

The landscapes were shared and commonly populated (doctors, technology, female and male bodies). There were desires in motion, constant connections, but also becoming and affections. It was precisely as Mia summed up, *“It is between you*

and your partner because you go through it together. It is something you do together. You are constantly aware of your partner. It is a very embodied experience. You are together non-stop.”

For every couple there was a moment when IVF technology and the doctors performing it no longer occupied the same territory the couples did. The pregnancy and the post partum period became a different landscape for the couples to populate and dwell in. The necessity to do a pregnancy test, a pregnancy test itself, ultrasound scans, a birth of a child and its presence all stood for powerful percepts that caused different affections and becomings of the female and male bodies. To have to do a pregnancy test was to become a ‘having-not-having-a-child-body’ for both women and men. It was also a becoming each other, each other’s eyes, each other’s voice, a becoming each other’s fear and hope. Becoming and becoming affected in such way, but also wanting to ease each other’s anxiety, almost all the couples decided to do the test together. *“My partner suggested buying the test and he did. He said: When you wait till the morning and it is not positive then you will be alone and you will have a bad day by yourself. If you do it now, at least I am at home and we can be sad together. We were checking and checking and checking”* [Dus]; *“From six a.m. I was sitting in my wheel-chair keeping myself busy. I was waiting for my partner to get home. I was so nervous. He got home. You could see one [line on the pregnancy test] immediately. The second took two minutes. We were both sitting and looking. I think I can see something. Look, look very small. I do not see it. Yes, yes, yes...it got bigger and then it was so obvious. We did the test and we were pregnant”* [Syla]. The becomings a ‘positive-negative-pregnancy-test-seen-body’, a ‘blur-of-the-ultrasound-body’, a ‘heart-beat-no-beat-ultrasound-body’ and a ‘new-born-baby-seen-heard-touched-body’ were the becomings a ‘heaving-not-heaving-a-child-body’ of the female and male bodies. Those becomings were the becomings each other’s smile, tears or silence, each other’s embrace, hands, arms or separation and distance, each other’s happiness, sadness or loneliness. *“When we came back home from the hospital we sat and cried together from the happiness. We could not stop our tears”* [Mon]. Those becomings resulted also in certain actions, i.e. started all over again (if there was no pregnancy or miscarriage occurred), deciding to go on with only one child, giving oneself some time to rest and postponing for a moment the decision of

coming back to the fertility clinics or remaining childless, or simply raising a child together.

Bodies can be affected by anything. The affects are produced after any type of encounter. It does not matter if it was a blur on the ultrasound screen, the smile of a partner or the hostile voice of the neighbour. The becomings and transformations, which I refer to as affirmative, unceasingly follow. Contrary to the Dutch, the Polish couples also experienced becomings caused by the necessity to pay for the whole procedure and equally by the circulating notions of IVF as 'producing' a commodity-like and strange-alien-artificial children. The desiring-becoming-affected-body is the creative and productive body with arelish for affirmative actions. The becomings of the Polish couples that came after the encounters with the mentioned percepts usually resulted in their 'defensive poise' or 'joke productions'. The Polish women I had a chance to talk to asked me rhetorically if her child differs in any sense from the children conceived in the 'bedrooms'. The Polish couples I had the opportunity to meet were sometimes joking about their child's possible commodity status. "*We paid for one and got two more for free.*" [Ali] [the couple had triplets]; "*We say to our daughter that when she grows up she will be paying us back*" [Viol].

The Female, Male and Children Bodies Without Organs

The interactions between the elements and fragments of any assemblage can have an outcome in certain deterritorializations, but can also trigger the 'emergence' of bodies without organs. The encounters between the technique, the doctors and the couples, but also between the female and male bodies, may result in the 'old-and-well-known' reproductive organs being dismissed from their reproductive obligations/sensations. The vagina and penis do not solely facilitate the whole process anymore. Yet human reproduction still occurs. More importantly however, when IVF takes place the female and male bodies still connect, the affects are circulating and get produced within the corporeal dimensions of the participating bodies (though as said vagina and penis are no longer the cause of them). The bodily linkages and the produced affects, to name only few, of love, empathy, gratitude, sympathy, compassion, happiness and kindness are never out of the scene. When the egg cells and the sperm get connected in a lab the partners' bodies connect too. The

partner's visible eyes, the becoming the 'partner's-eyes-seen-body', the partner's audible voice, the becoming the 'partner's-voice-heard-body', the partner's tactile hands, arms, faces, the becoming the 'partner's-touching-hands-arms-faces-touched-body', the partner's olfactory and gustatory lips, the becoming the 'partner's-lips-smelt-tasted-body'. The pleasure is never left aside. Those bodily connections/becomings are the becomings of being/getting affected. The love is never out of the picture. When in vitro occurs, no one wants to be offensive towards vaginas and penises. There are constant connections between the bodies and the production of affects of love. The only difference is that it is the other organs such as eyes, throats, vocal cords, ears, lips, hands, faces or arms that prove their connective abilities and capabilities of the production of the affects. Furthermore, the interactions between technology, doctors, female and male bodies may result not only in the different organs being involved in reproductive obligations/sensations but they also make those different organs 'do things' what even the reproductive organs could not do. Proof? Here it comes. In certain Dutch medical centers aspiration and fertilization does not happen in the same place. Therefore, the egg cells must be taken to another center where they will be mixed with semen. How is it done then? *'They put eggs in little tubes. They attached them to my husband's abdomen because they have to be kept at body temperature. You, as a parent, are the most reliable source of transportation [this is what is said in the hospitals]'* [Mia].

The Female, Male and Children Bodies and Assemblages

The Importance for the IVF Debate

The changing in vitro assemblages and the peculiarities of the female and male bodies are not my personal fantasies or made-up fairy tales. They are real and they exist. The landscapes of the 21st Century are capable of hosting a multitude of various, yet crucial, elements and fragments so intrinsic in their topography. Human in vitro fertilization stands for an assemblage that spreads in time and space. In addition, female and male bodies do belong to it. It can also dissolve and disappear when the couples enter the pregnancy and the post partum period. Female and male bodies are not really in love with phenomenology that still puts a line, though a tiny one, between them and the world. They are no longer interested (and in fact never have been) in the negative Hegelian oppositions between the self and the other.

There is also little patience for transcendence. There is, rather, an absolute admiration of radical immanence that causes and stands for the erasure of harmful borders and deadly petrifications. The desiring yet singular female and male bodies connect, become, become external and become affected. The deterritorializations and dismantlings, which vary in intensity and speed, stand for their daily bread. The female and the male bodies connect with everything that occupies their territories and so they also connect with each other enjoying their own singular externalizations and deterritorializations. While connecting and becoming, the female and the male bodies get affected. The produced affects stand for a 'basis' for the 'actions' that follow them as well as trigger proceeding becomings. The bodies in question regard Cartesian body/mind argumentations with suspicion. They embrace *zoe*, natal power, and 'saved-and-stored' in 'memory-banks' percepts and affects. They do sense and perceive. They enable the mental processes, emotional sensations and remembering of the human subjects. They are psychic, emotional and remembering. They are the indispensable basis of the human's subjectivity.

To see in vitro as a changing assemblage the female and the male bodies are the parts of, not to forget the pregnancy and the post partum period and to recognize the abilities/peculiarities of the human bodies, is to be able to propose more adequate assessment and conceptualization of but also approach to human in vitro fertilization than those articulated by the Vatican. This is not only because it allows recognition of the billions of interactions/happenings between the bodies and technology, but also within the bodies and between the bodies. Furthermore, the assessment may be much more positive.

To look at in vitro as an assemblage, to see the desiring female and male bodies as its crucial elements and to spot *zoe* in the picture is to doubt if the technique can, in fact, take the bodies in question and the reproduction under full control. In the former Section, while discussing the issues of control, I have already pointed out that no one can actually grant the negative power of dominance to a particular fragment of in vitro assemblage. This is because it cannot be anticipated *a priori* what the results of the particular encounters and connections will eventually be. The variety of the becomings of the participating bodies and the different 'types' of the produced

affects may actually have a lot to do with positivity and create a basis for creative and powerful (*potentia*) actions of the embodied subjects. The Vatican worries that the technology will turn doctors into demi-gods and certainly one should not immediately discredit such statement. Yet, with in vitro perceived as an assemblage and with the female and male bodies as becoming/affected and ready for a creative 'action-reaction', it can be expected that the creation of the demi-gods can be successfully prevented. Moreover, as doctors themselves also undergo various becomings and get affected when connecting/interacting with couples, it can be expected that their appetites for control and domination will not always be satisfied. Furthermore, if it is up to a desire to create the assemblage and set it in motion, it is also rather awkward to talk about tight supervision, the finest control over or the victimization and oppression of the female and male bodies when in vitro technique is at stake. What is more, with the unpredictable *zoe* in the background, who can state with absolute certainty and conviction that both the body and its reproduction can be entirely and successfully monitored enabling technological supremacy to reach it's peak? Moreover, seeing in vitro as a changing assemblage, it becomes obvious that elements and affects other than technology and doctors matter equally and may result in becomings and affections that allow the couples to live their mixed-with-in vitro-life in a very affirmative way. Next to that, not to omit the pregnancy and the post partum period in the discussion is to confirm that technology with its toolbox and in vitro doctors may eventually dissolve into a 'thin air'. Therefore, it can be said that the female and male bodies, and the very life of the couples, go on without a complete technological supreme take over. To comprehend that *zoe* is a generative power, to understand that human life is about production and continuity and to realize that female and male bodies as '*zoe*-bodies' equipped with natal potency/power are able to generate life, is to again evaluate in vitro as a catalyst of the life's productivity and continuity. The 'recognition' of such potential is, in fact, what the Vatican has always been in favor of. Furthermore, to recognize that both female and male bodies have the potential to generate life, but that this does not have to be in fact actualized, is to assess IVF as a possible catalyst but also (and again) as not taking the female body and reproduction under absolute control. To see in vitro as a changing and disappearing assemblage, but also to recognize the peculiarities of the bodies, is also to undermine the Vatican's conclusion regarding

bodies and the human subject when faced with assisted reproductive technologies such as IVF. According to the Vatican, to repeat briefly, when in vitro takes place female and male bodies cannot really connect. As the connection between the bodies is lost, love (spirit) cannot be expressed, and as a result, the body becomes reduced to nothing more than its pure physiology, tissues, organs, etc. The body is reduced and thus objectified and dehumanized. As a result, the human subject no longer stands for unity. It undergoes a split between the body and the spirit, thus resulting in objectification and dehumanization. Due to this, the human subject is faced with the loss of its dignity. However, I want to argue that the bodies do connect. There are countless connections and linkages between the bodies. There is not a single moment when the bodies do not connect. To see, to hear, to taste, to smell and to feel (i.e. when it comes to touch) is to connect. To see a smile, tears, pain, sadness or happiness; to hear somebody's voice, shouts, complaints, grief or euphoria; to taste somebody's lips, to feel somebody's hug or squeeze means to connect. Those are precisely the connections between female and male bodies that happen and at the same time forecast their externalization. Female and male bodies not only connect, though the Vatican is very skeptical about it, but in fact become each other. The female body when seen, heard or touched enters the spaces of the male body. There is a specific externalization and deterritorialization of the male body when it becomes its female partner's eyes, hands, tears, smiles or hugs. The female body also undergoes affirmative externalizations when becoming her male partner's words or arms. Thus, in my opinion the Vatican's statement that the connections between female and male bodies are lost when in vitro and couples meet can, in fact, be undermined. When the human body is seen as sensing, perceiving, psychic, emotional and remembering, but also full of the previous percepts and affects and constantly becoming affected, then certain conclusions can be drawn. First of all, I want to say that the body can never be reduced to its physiological dimension, 'dumb' tissues and organs and certainly not because the body/subject opts for in vitro. It is the body that enables sensing and perceiving. It is the body that makes it possible for the 'stored in the memory banks' percepts and affects to enter the scene and allows new percepts and affects to join them. It is the body that facilitates mental processes and the experiencing of emotions. In this sense, the body cannot ever be seen as unable to experience/express its emotions, including love. Secondly,

whenever there is contact between bodies, the bodies become and they become affected immediately, responding by becoming the love, happiness, horror, empathy, sadness, regret or hope. Therefore, to say that when in vitro is at stake, love cannot be expressed and the body becomes reduced, does not seem to be right. Furthermore, with the body as the basis of subjectivity that is full of external, memorized and produced affects, to use the rhetoric of the possible split of the human being is to definitively be under Cartesius' spell. If then the bodies do connect, love is expressed, no reduction or split occur, then it seems possible to me to say that no objectification and dehumanization occur and that the human being does not lose its dignity when IVF is in motion. To see vitro as an assemblage of which the female and male body constitute the essential parts, and to recognize the peculiarities of the bodies, is to suggest that to a certain point those are the elements/affect intrinsic to IVF technology and IVF doctors due to whom the female and male bodies start to connect, become each other and get affected. In this sense I want to risk saying that in vitro not only does not result in the lack of connections between female and male bodies and so prevents love from being expressed but, in fact, creates, supports and fuels them (connections). Of course, the becomings, produced affects and following them, 'actions-further-becomings' do not always have to be positive. However, in my view, this has much more to do with the singularities of the human body's becomings and its unique interactions with and selections of percepts and selections of affects than with in vitro *per se*. And of course, affected either way, women and men go on precisely because the affection is a spark, a force that is followed by another becoming and another produced affect. So the believed negativity of IVF (fears, grief, sadness or anger) is rather a mark, a side-effect of a culture in love with names, frames, definitions and, certainly judgment. Furthermore, to comprehend that desires that 'adore' connections do govern human subjects, is to conclude that nothing can stop 'one-body' from creating 'shared-spaces', making alliances and reaching out to another one (i.e. the women and men teaming up with each other and caring for each other when going through in vitro, the pregnancy and the post partum period). What is more, to focus on the pregnancy and the post partum period, and again to comprehend the desiring and easily affected spaces of the human body/subject, is to once more astonish oneself with the fantastic bodies in love with linkages, alliances and desiring-productions. Therefore, to argue again, as the

Vatican's does, that in vitro has something to do with the stoppage of the connections between female and male bodies, calls for nothing but suspicion. Moreover, when in vitro is seen as an assemblage, female and male bodies as its parts and when one comprehends that bodies can get rid of their organs, is to again doubt if IVF should be accused of causing the bodies to lose connections. It seems that instead of blaming in vitro for the disruption of linkages between bodies, it should be seen as a stimulator and also amplifier of those connections. The point is that when in vitro takes place, the bodies not only connect, but in fact have more organs to do so. Isn't it comforting to realize that one has more organs to connect and express love with than only a vagina and a penis? Isn't it good to know that when in vitro is at stake, the connections are still there, the love is still there, the pleasure is still there, the vagina and penis can have some rest and yet reproduction occurs? I think it is. In addition, as female and male bodies do connect and love does not go out of the picture, then I can argue that the child does 'stand' for the living image of love, is linked to the union of its parents, is not deprived of perfection and its dignity is preserved. What is more, if one realizes the number of the female and male connections, the billions of circulating and produced affects (i.e. affects of love), but also following them, actions of the embodied subjects (i.e. continuation of the procedure) when IVF is in motion; then to say that the child is not a living image of its parents love is actually rather outrageous. In fact, IVF should not be assessed as 'producing' children that are not a living image of love, but to the contrary. The desiring-production and actions of the embodied subjects (i.e. going through in vitro technique and practice) indicate how much the couple love each other, how much a child is wanted and how much it is going to be loved. Therefore, the statement that when IVF is at stake the child is desired as the product of intervention of medical technique and so reduced to an object of scientific technology can be undermined. To me, IVF is a tool and at the same time a measure of women's and men's degree of, affirmative dedication and love for/of a prospective child. Moreover, if the bodies are seen as external then the reproduction cannot be immediately described as disembodied. Certainly the fertilization occurs in the lab, thus one may easily talk about its disembodiness. However, such a conclusion results from certain manners of understanding a 'reality' that recognize a body as enclosed in its stabile frames and borders and being separated from the world. If, however, the peculiarities and

capabilities of the human body are fully comprehended, then I can say the body and the world do not constitute two separate units. The body and the world become together, at the same moment resulting not in one or two units, but plenitude and multiplicity. Thus, even if fertilization happens in the lab, the body that is conscious of it does not let it go but sucks it inside, not allowing the disembodiment to take place. What is more, if the pregnancy is not omitted in the debate, then it becomes obvious that the child develops and grows in the female body. Therefore, to talk about a 'full-real' disembodied reproduction and as such its objectification and commodification, does not seem to be truly fitting. Moreover, the affected and desiring bodies will strive for productive and affirmative actions (i.e. parents will not perceive their child as a product or commodity). Taking everything I said under consideration, is the Vatican right when saying that with in vitro technology a 'real family' cannot be formed? After all, the corporeal connections and affects are there, no body-reduction and human being split takes place, a child 'stands' for a living image of love, is linked to the union of its parents and its perfection and dignity are safe and secure. Shouldn't we then speak about family? I think we should not only approach family formed thanks to IVF as a family, but in fact almost a 'super-family'. Why? Because it is a 'family' whose creation involves endless connections between the female and male bodies, exchange and production of billions of various percepts and affects, usually translated into affirmative actions, and in most of the cases, long yet desiring-production (that culture would refer to as, among others, dedication and an indicator of a love for/of a prospective child). To me IVF does not destroy a family but it helps in creating 'super-families' whose foundations are constituted by larger than life connections between female and male bodies, by a powerful (*potentia*), creative and productive desire, but also to borrow from a cultural terminology, dedication and love for/of a prospective child.

With the proposed ways of debating IVF, the approach to this technique can also be more positive than the one suggested by the Vatican. I have already repeated many times that it is not a good idea to state that IVF should not be approved and I will say it once more. IVF seen as assemblage together with its constituting desiring, becoming and becoming affected female and male bodies makes one think twice before suggesting the non-approval of in vitro. To say that something is dominating

and controlling is to forget about creativity and productions enabled by various affections. To state, as I have argued before, that something results in various negative emotional hardships such as fear, grief or sadness is a cultural judgment as 'everything' may, after all, be turned into affirmative/productive/creative activity. On the other hand, to comprehend how connective the bodies are, to realize their constant exposure to the countless percepts, to see that they constantly become affected and that the produced affects trigger other 'actions-becomings' then it would be good to assure that they are the optimal ones.

The proposed manners of discussing human in vitro fertilization that suggest seeing it as a changing assemblage of which the female and male bodies equipped with their capabilities constitute an essential part but also do not omit the pregnancy and the post partum period, allow proposition of its new concepts. This medical technique does not have to be defined as entirely controlling, turning doctors into demi-gods and triggering technological supremacy over bodies and reproduction. On the contrary, it can be described on many occasions enabling affirmative actions which are also aimed at diminishing doctors' appetites for the control over the embodied subjects. Furthermore, in vitro method can be conceptualized as a stimulator and amplifier of the female and male bodies' connections/affections that can again result in a very creative and affirmative 'experience' of life by the couples participating in assisted reproduction. Moreover, IVF technique can be defined as a tool, a measurement of the degree of women's and men's affirmative dedication and love for/of a prospective child as well as a technology that has a lot to do with the creation of the 'super-families'.

PART II

Suggestions and Recommendations

The body can apparently do a lot and is very peculiar in its materiality. The body is not transparent and can be very unpredictable. The life of the body cannot be fully understood, monitored or taken under control, and yet it is full of generative powers. It is about the productivity and continuity. Desire never rests and stands for an important fuel for any human subject. IVF is a changing assemblage of which the human body is a part, and may be followed by the pregnancy and the post partum

period. IVF appears to have much to do with productivity and positivity. IVF in motion is about linkages and connections and not invasions. When IVF takes place it is difficult to say what the outcomes of various encounters between technology, doctors and patients may be and to speak about domination of one element over the other. The women who participate in human in vitro fertilization do not appear to be the allured and oppressed victims, the speechless marionettes, the suppliers of the genetic material with no control over their own reproduction. IVF's toolbox becomes a body's material reality. The toolbox and the doctors get transformed into new, useful for the body organs. The technique and practice both have to do with the percepts and affects rather than with the "artificial invasion", dismembering and reduction of the human body. IVF is not about disembodied reproduction. Both technique and practice stand for the affects, which are not necessarily about negativity but affirmative actions. They are also the percepts that can completely lose their force and not be able to affect anymore. Human in vitro fertilization does not stand for the source of the subject's various hardships and anxieties simply per definition. Anxieties can be experienced, but it all depends on the body's selection and interaction with incoming percepts. The hardships and anxieties can be transformed into affirmative actions. The couples experience physical pain but also enjoy the ride to the hospital. They cry, but also make jokes. IVF technique is not superior towards the body and it does not result in the dehumanization of the body as the body has already been inhuman for quite some time. Technology and its practice affect bodies differently and are not oppressive and abusive to everyone, everywhere. They do not fully dominate women's lives or take the control over reproduction out of their hands. The life of the couples goes on without a technological take over. IVF may stand for a type of a medical help. It is a tool used by women to achieve their goals. It is one of the many events they participate in, an occasionally visited space. It is also a stimulator, an amplifier of the female and male bodies' connections/affectations (which do not only occur between the reproductive organs) and a measurement of women's and men's degree of affirmative dedication and love for/of a prospective child. IVF adds to the creation of 'super families' that are all about connections between and affectations of the female and male bodies, a powerful (*potentia*), creative and productive desire but also dedication and love for/of a prospective child. Both partners are usually involved and both are affected either by

IVF technique and practice or by their (women/female bodies-men/male bodies) mutual encounters. The created affects differ and so do the actions following them. The women and men usually try to discuss their situation, make efforts to understand and help each other. They also look into the future trying to anticipate what can or should be done if IVF turns out to not be an option anymore. Non-approval of IVF may become a barrier 'on the road' to a possible empowerment of the woman/female body and it may stop the motion that can lead to positivity and production. On the other hand, the optimal 'shapes' of IVF assemblage's elements may enhance the flows and have positive outcomes. The IVF technique can indeed result in physical pain and its practice may get turned into less than fine sensations. It is true that not much can be done about the prevention of the physical pain but much can be done about the practice. The behavior of the medical staff, the way the technology is used and organized are very crucial for the female body's becomings. In Poland, tranquilizers and anesthesia have found their place in IVF technique's toolbox and doctors' hands to minimize the possible pain during egg cells aspiration.

In Poland, the Vatican's and the Polish Catholic Church's rejection and condemnation of in vitro has had its consequences in the ways IVF is organized, performed and perceived by Polish society (see also Chapter Three and Four). Unfortunately, the public attitude does not usually result in sympathetic reactions. Therefore, many women who did in vitro experienced fears and grief during their pregnancy. Mon's friends knew that she visited an infertility clinic yet when she got pregnant she pretended that the conception had nothing to do with in vitro. *"I told them that we did not need in vitro. I said that my husband was taking medicines, stopped smoking and drinking. I feel so ashamed that I did that but I could not tell the truth"*. The fear and grief were transformed into affirmative actions (thus no negativity was after all at stake) yet the affects of fear and grief were definitively present. No one likes to be accused or attacked and no one wants their children to be called names, joked or wondered about, thus one tries to be silent and careful. Many times the Polish couples had to lie and make up various stories in order to visit the medical centers together. They had to negotiate the involvement of money, the possible notions of commodification and strange-IVF-creations when it came to their child. Thus, the couples lost much energy on creating lies and making up the stories.

In Poland, because of the ways in vitro is organized and approached, which has been greatly influenced by the Polish Catholic Church following the Vatican's lines of argument, the couples tried hard and lost energy to make their in vitro 'reality' the most bearable one. The experience of the Polish couples was alien to the one of the Dutch couples. No lies had to be told and no negotiations took place.

The proposed theories and manners of discussing in vitro, the more accurate and balanced evaluation of, concepts of and approaches to IVF but also the descriptions and presentations made in Part I of this Chapter, result in certain recommendations for the Vatican, the radical feminists, feminist and those involved with men's studies of how to 'go about' IVF technique and practice.

As I have already mentioned in Chapter Three and Four, the radical feminists and the Vatican should stop calling for a non-approval of human in vitro fertilization. Moreover, the fertility-infertility issues and IVF itself must be made known and well explained, with all the 'pluses' and 'minuses' to the public at large. It is also advisable to remove the taint of commercial enterprise from the medical procedures that deal with fertility-infertility matters. Furthermore, when it comes to IVF technique and practice, they both may definitively become a negative 'experience' if one deliberately desires that. However, it does not have so much to do with technology *per se*, but rather politics, economics, laws, directives, arrangements, beliefs and ideologies influencing its practice (see Chapter Three and Four). Thus, it is crucial to strive for the constant supervision of IVF practice. In my opinion, the best supervision does not come from the field of politics or scientists (who *nota bene* must be supervised themselves). It is really fine to have them in a team, yet this team must also include, among others, those whom the decisions concern, who happen to participate in in vitro or are just about to do so. The bigger the assemblage, the more becomings can take place, the more affects can be produced and so the better the results as Paul Patton would have said.³⁷

³⁷ Lecture "Deleuze, politics and political normativity" by Prof Paul Patton, University of New South Wales/Wissenschaftskolleg zu Berlin on March, 27, 2008 at Utrecht University, Utrecht, The Netherlands

The proposed theories and manners of discussing in vitro, the more accurate and balanced evaluation of, concepts of and approaches to IVF but also the descriptions and presentations made in this Chapter result in important suggestions regarding feminist theory and men's studies theory.

The happenings that take place between the human/body and technology, or better technologies together with their outcomes or anticipated outcomes, are controversial and evoke many discussions. Different scholars, and among them some feminists, to mention only few: Rosi Braidotti, Anne Balsamo, Donna Haraway, Katherine Hayles, Claudia Springer, Vivian Sobchack, Mike Featherstone or Roger Burrows have been deeply engaged in debates which have at their center these techno-human/body relationships. What occurs between the human/body and new techno-devices on the material level has been approached and discussed from various perspectives. In some academic and non-academic writings technology is described and presented as a savior, a possibility, a promise of a better life, a fantastic enhancement of the human's/bodies' capabilities and a freedom from different restraints and limitations. In those debates the human easily becomes post-human with no regrets or mourning. Yet, with the glorification of technology it also seems that the body is in danger of, or already undergoes, degradation and a peculiar abandonment. Rosi Braidotti refers to this while pointing out that, "*The corporeal site of subjectivity is simultaneously denied, in a fantasy of escape, and strengthened or re-enforced*" (Braidotti 2002:223). The body appears to get a status of nothing more than an unnecessary burden, an imperfect relict, and at best a good object of jokes. The body seems to be useless and utterly redundant, whereas the techno-world appears to bring great solutions and be all about perfection. One may conclude that bodies are weak and get rotten very quickly when browsing William Gibson's Neuromancer (1984). Bodies can also be boring as they leave one with unfulfilled promises of pleasure and excitement, enough to watch Cronenberg's Crash (1996). However, for some scholars or for that matter institution that I have a polemic with, and here I can refer to the Vatican or the radical feminists, it is not easy to say goodbye to the human. Apparently, the price to pay for the 'loss of the human' can be very high. This, at least, is the message of movies such as: Disturbing Behavior (1998) by David Nutter, Lawnmower Man (1992) by Brett Leonard or The

Manchurian Candidate (2004) by Jonathan Demme. Similarly, the possible ‘fall’ and abandonment of the body is not accepted with ease. The so to say ‘fall’ and abandonment of the body makes other academics or non-academics such as Balsamo or Sobchack rather angry and puts them on ‘body-rescue expeditions’. In their counter polemic, the body becomes conceptualized as the inevitable materiality, the grounding ‘reality’, the *memento mori* and the *sine qua non* of one’s existence. The body is “(...) *what grounds the concrete gravity and value of life, with the pain that would always remains that we are the bodies or that we will always have to return to the embodied reality of the empty stomach, stiff neck (...) because life is still lived through bodies*” (Sobchack 1995:213). Technology is not entirely condemned and rejected, however, the body is granted a superior status. I do not want to criticize those highlighted approaches as they might make one wonder or be critical regarding the contemporary ‘conditions’ of the human/body. If I had to choose, then I would definitively be more sympathetic to Balsamo’s and Sobchack’s points of view. However, I am honestly not very much in favor of either. What I find problematic is that the human/body and technology are approached as two ontologically different, thus radically opposite units. Therefore, the moment the material and contemporarily living cyborgs become the objects of debate; the human/body and technology relationships are seen in terms of binary oppositions and assessed accordingly. Those worshipping the hard steel or precision of chips would always look down on the carbon and water-based entities (organic forms of living) that can be easily defeated and destroyed. Those familiar with the pain of the decaying cells and dysfunctional tissues and organs would not easily fall for the steel and chips. Furthermore, as technology is different from the human/body, thus it is the other, and as such dangerous, then it is of no surprise that the intimacy between those two is not assessed as doing much good to the latter one(s) (bodies) and described as for example the “artificial invasion”. What I would like then to suggest is to stop approaching the human/body and technology as ontologically different and to stop seeing the techno-human/body interactions in terms of the binary opposition. Language that likes to enclose everything in ‘impenetrable-framed-definitions’, cannot easily be overcome, thus let me stay with the ‘technology’ and the ‘human/body’ wording. However, I want to trust the creative imagination that can take one a bit further in one’s negotiations of one’s ‘reality’. I can assume that it

could be difficult to accept the erasure of the ontological difference between the techno world and the human/body's landscapes. Yet, as Braidotti emphasized, "(...) *postmodernity is the historical time when such ontological distinctions collapse (...)*" (2002:225). She also stressed that, "*The cyborg (...) breaks down the dualistic barriers between the body and its technological and technical supports (...)* *The cyborg functions rather as a counterparadigm for the bodily intersection with external reality; it is an adequate reading not only of the body, not only of machines but rather of what goes in between them*" (Braidotti 1994:108). Instead of conceptualizing technology and the human/body as fundamentally different and of seeing techno-living organism encounters in terms of binary opposition, can those encounters/interactions not be approached as a space for the emergence of the changeable plentitude of difference and as a space of becoming/production? After all, as Grosz argues referring to Deleuze, "*Subject and object are series of flows, energies, movements, strata, segments, organs, intensities-fragments capable of being linked together or severed in potentially infinite ways other than those which congeal them into identities. Production consists of those processes which create linkages between fragments, fragments of bodies and fragments of objects*" (Grosz 1994:167). Certainly I am aware of a possible resistance. I am also aware that to erase the distinctions between the techno and the organic worlds can be taken for an inconsiderate action. Yet, the ontological difference and the binary opposition seem to lead only to negative statements such as the "technological supremacy" or the "artificial invasion". This kind of negativity may easily result in either fear, which culture likes to define *a priori* as a rather negative emotion, or as Braidotti would put it, melancholia. Fear as any emotion-affect can, have its outcome in not a decrease of one's powers, but in production. Yet, I guess it is better not to create situations where one may possibly lock oneself in a fortress of one's four walls and probably diminish/terminate one's own or the other's intensities, becomings and flows. To look at the techno-human/body's relationships as the emergence of a space of the variable multitude of difference and of a space of becoming/production, is not to talk about the "artificial invasion" and is also not to talk about the "technological supremacy". Therefore, in my opinion to approach the techno-human/body's interactions in the proposed way can significantly diminish fears and melancholic sensations. I think it is much better to trust that those relationships are not about the

“invasion” or “supremacy” but about engagement with others (in this sense technological others), becomings and production. The proposed theories and manners of discussing in vitro, the more accurate and balanced evaluation of, concepts of and approaches to IVF, but also the descriptions and presentations made in this Chapter allow coming up with theory that with IVF the techno and the organic worlds blend, creating the space of difference and of becoming/production. Such theory is possible as IVF technique is said to have a twenty-five percent chance of being successful and seventy-five percent of not. Those twenty-five/seventy-five percent statistics indicate that there is something happening in-between the human/body and technology. Thus it can be said that with IVF there is no longer only the human/body or technology, but a third entity-quality. *“The merger of the human with the technological, or the machine-like (...) results in a new compound, a new kind of unity (...) [which] is neither holistic fusion nor Christian transcendence-it rather marks the highlight of radical immanence. It is not biology but an ethology of forces-an ethics of mutual interdependence”* (Braidotti 2002:225). This entity-quality is again no longer only about the body nor about technology. It becomes the expression of difference. It indicates a particular becoming and a particular production. The becoming and the production are both enabled by technology and by the human/body, yet no one can say that it is going to be the technology that will get a priority, that will become superior in this postmodern tango and reach the status of the invader. There are no ontological distinctions, no binary oppositions, but the space of the radical difference, of becoming and production: one big plane of the radical immanence. Of course, one can wonder if such a space is about negativity or positivity. Then I would say that if it increases one’s powers to act and when one’s action does not block the flows and the intensities of the others, then one should not worry. But again, the final outcome thus probability of positivity or negativity can never be *a priori* anticipated. Yet, should one then stop the flow in case the flow will flow where no one wants it to?

The ontological difference established between the human/body and technology, the binary oppositions, the concept of technology as the dangerous other, but also the larger than life attachment to anthropocentrism, fuels the mourning over the human as a dehumanized entity when in relationships with the techno-world. It is precisely

this attachment to anthropocentrism that will assess the interactions with others, in this case the technological others, as having to do with dehumanization and evoking fears or melancholic sensations. To realize that the techno-organic relationships stand for the expression of difference, becoming and production on the plane of immanence is to also comprehend that what we call the human is, and has always been, as Deleuze (1983) writes, inhuman. Yet, this inhumanity of the human is not about negativity and does not have to be feared. In fact, to realize this inhumanity in humans is to become less fearful, less negative and ready for affirmative actions and, as Braidotti would say, the affirmative engagement with and opening up to various others³⁸ (not only the technological others). As IVF stands for assemblage and the human body constitutes its part undergoing various becomings, it can be said that with this technique and practice, affects that get produced during the whole in vitro procedure ‘combine’ in themselves the techno and the human elements. Yet there are no more distinctions between them, but ‘one’ entity that is all about multiplicity. Those produced affects do usually stand for the productive and empowering forces. Even if there could be an affect that would stop the flows, it, again, cannot be anticipated *a priori*. Assemblages, such as in vitro, are very mobile and do consist of many elements thus many various affects have chances to get produced. As such, it can be said that with IVF the inhuman affects make one more human if human is to be a positive entity with positive degrees of speed and slowness of its intensities and flows.

The fact that IVF stands for an assemblage and because the human body constitutes its part and ‘experiences’ nonhuman becomings-affects and undergoes processes of deterritorialization, allows for the theory that with IVF the concept of the human/body as ‘natural’ and the concept of the ‘nature’ and ‘natural’ itself can be questioned. Furthermore, with such theory the concept of woman as linked to irrational ‘nature’ that little resembles the predictability of reason can also be undermined.³⁹ It also makes it possible to state that with IVF, there is no distinction

³⁸ Lecture “The politics of affirmation” by Prof Rosi Braidotti , Utrecht University on March, 27, 2008 at Utrecht University, Utrecht, The Netherlands.

³⁹ The humanism or modernism constructs the man as a subject that is universal, present, conscious, rational, and active--mainly connected with mind, transcendence, and culture, being usually the subject of desire, whereas the woman is usually described as an object, that is particular, lacking, unconscious, irrational, passive, emotional in contrast to man, connected with body, immanence,

between mind and body and so the human is, and has always been, an undivided unity. Yet, this unity is at the same time a non-unity in the sense that it expresses the externality, thus the radical inhuman difference of the human/body. Rosi Braidotti in Metamorphoses (2002:226) makes the reference to Eric White's position on the human body. I would like to borrow the quotation as I find it extremely relevant at this moment of my discussion. For Eric White (1995:252) "*the body is not a perfectly resolved unity endowed with a unique and everlasting essence but an evolutionary makeshift, a historically contingent contrivance whose genealogical affiliation with every other kind of organism is manifested throughout*". Such theories may help those being in 'reproductive age' and those opting for technological mediation in reproduction in the sense that those who feel negatively different when 'mingling' with technology, can stop feeling so.

The whole discussion in Part I also makes it possible to say that with IVF, which makes the impairments of the female, but also male bodies visible, the man appears to also have a body (that does not have very much in common with those of Apollo's or of Da Vinci's drawings) and not only the rational and objective mind.

The discussion equally allows risking a theory that with IVF, which is all about the production of affects-emotions, the *ratio* seems to be never more dominant or more important than the emotions-affects, which are intrinsic to both women/female bodies and men/male bodies. It also makes it possible to come up with the theory that with IVF it appears that love and pleasure can be expressed by other organs and not necessarily the vagina and penis which are, as Braidotti emphasizes, "*(...) coded as the areas of intense concentration of bodily sensations and pleasures (...)*" (Braidotti 2002:140). Theory that emphasizes that with IVF, the woman/female body and the man/male body seem to be in the possession of more sexual organs than the culture would like one to believe. "*(...) the despotic power of the Phallic signifier (...) is imprinted on the subject as an internalized form of despotism which is exemplified by*

nature, being usually the object of desire and phantasy. Never regarded as "the agent of history, the significant and autonomous being, but as a mirror for man, his servant, accommodation, tool, commodity, the possibility of the reproduction of his species and his world"³⁹ (Sadie Plant, (1995). *The Future Looms: Weaving Women and Cybernetics*. In: Featherstone, M., Burrows, R., (eds.). Cyberspace/Cyberbodies/Cyberpunk. Cultures of Technological Embodiment, London, SAGE Publications Ltd., 58).

the power of conscious self-reflexivity over the heterogeneous, surging and potentially chaotic mass of libidinal affects” (Braidotti 2002:124).

The proposed theories regarding the human body and descriptions presented in Part I make it possible to propose the theory that the woman/female body is in constant motion. This motion is familiar with endless processes and transformations, stands for the non-easily predictable outcome of the ceaseless negotiations between the inside and the outside, the inside affects and the outside percepts. However, this unpredictability is not about negativity but creative possibility. The woman/female body is what it can do and what it does. It is not a “molar aggregate” but a “collective assemblage”.⁴⁰ At the same time, it can be said that the man/male body is not about a “molar aggregate” either, but a “molecular composition” of not easily predictable shapes.⁴¹ It is what it can do and what it does. Rosi Braidotti puts it as follows, “(...) *this environmentally bound subject is a collective entity, moving beyond the parameters of classical humanism and anthropocentrism. The human organism is an in-between that is plugged into and connected to a variety of possible sources and forces. (...) [It is] something that is simultaneously more abstract and more materially embedded. (...) Being environmentally bound and territorially based, an embodied entity feeds upon, incorporates and transforms its (natural, social, human, or technological) environment constantly*” (2006:41).

The fact that life is about creation and continuity and that human bodies are the ‘zoe-bodies’ equipped with natal powers and are able to generate life allow the theory that life is a positive and affirmative process and that female and male bodies are equally positive and affirmative entities. Such theory may be used to diminish the overwhelming fear of Thanatos, but also feelings of melancholia and depression that human existence is nothing more than “*vanitas vanitatum, et omnia vanitas*”.

The radical feminists in their theory, in fact, reduce female power to generate and commence life to *potestas* (i.e. the notion of the obligatory and imposed

⁴⁰ The comment made by Rosi Braidotti during discussion regarding the human bodies and subjectivities on April 2008.

⁴¹ For more on molar and molecular please go to Gilles Deleuze and Felix Guattari (1987). *A Thousand Plateaus. Capitalism and Schizophrenia*, London and New York, Continuum.

motherhood). Yet the discussion in Part I allows suggesting that those powers should be theorized as *potentia*. Furthermore, the very fact that the male body may also generate life, though in a different manner, makes it possible to not only theorize the male body as a reproductive body, but also to endow ‘his reproduction’ with positivity as again having to do, not with *potestas*, but *potentia*. This theory may help to realize that to have or not to have an offspring is, to put it simply, very all right and should not be linked with negativity. Not to have a child is another option chosen; to have a child is natal powers/*potentia* actualized. Both ways have to do with positivity as both are about desiring-productions and increased powers of acting/doing/interrelating.

Those involved in issues linked to assisted reproduction are very much aware that IVF definitively changes the ‘old’ concept of family based on blood ties, genetic connections and the transparency of who is who to whom. It might seem scary and dangerous precisely because in the culture ‘we’ all live in, it is widely believed that *“Clarity about who your parents are, clarity in the lines of generation, clarity about who is whose, are the indispensable foundations of a sound family life, itself the sound foundation of civilized community”* (Leon Kass cited in Stanworth 1987:19). Furthermore, this clarity Kass is talking about, again in the culture ‘we’ all live in, appears to be really important for one’s sense of belonging and security. Stanworth makes this very clear saying that, *“(…) the poignant publicity given in the past fifteen years to the search for genetic mothers and fathers by children born of artificial insemination by donor, or by adopted children, emphasizes the idea that genetic connection is an immutable and overriding element of identity. Through those overlapping sets of ideas, blood ties have come to stand in our culture as a symbol of permanence in human relationships – and the more fragile and contingent other relationships seem to be, the more compelling that symbol’s appeal (...)”* (1987:21). There is a socius and linked to it particular ways of thinking/reasoning/feeling that cannot easily let ‘things’ go that constitute the basis of the socius itself.⁴² It is quite apparent then that the efforts have been undertaken (i.e. the abolishment of the donors anonymity in the Netherlands) in order to not allow for a total dissolution of the familiar, the stable, the safe, the socius that ‘we’

⁴² For more on the “socius” please return to Chapter Four or read Gilles Deleuze and Felix Guattari (1983). *Anti-Oedipus. Capitalism and Schizophrenia*, London and New York, Continuum.

all know and ‘obviously’ feel secure within. I am completely aware that it is not easy to accept such a significant shift, meaning the disappearance of the blood and genetic ties. I am also entirely conscious of fears and resistance such transformation may evoke. I can also understand the advocacy for the non-anonymity of donors. The children conceived from the anonymous donors may not always have it easy in the present culture still in love with the ‘already old yet still very present’ norms, regulations, beliefs and values.⁴³ However, changes on the material level, triggered by techniques such as IVF, are already taking place. The whole discussion in Part I that indicates that it takes quite a lot of a production, various encounters (with different others including the technological others), becomings and deterritorializations for a child to arrive when assisted reproduction is at stake and that the people who happen not to have such ties and connections still may share the same space and occupy the same landscape, still care, still get positively affected, still love and still have a “sound life” allows proposition of very interesting theories. Theory that with IVF, reproduction becomes a set of collective and affirmative assemblages of unknown *a priori* outcomes. Theory that with IVF the family is not that much about ‘blood-circles’ and ‘genes-spirals’ but rather desiring productions, externality, deterritorializations, becomings, affects, affirmative actions, engagement with all the possible others the technological others including. Theory that with IVF the family has moved beyond the “stratification”.⁴⁴ The point is that the IVF family gets created within the space of difference of becoming/production and inhumanities, thus within a space where the strata of the human/body gets dismantled; where, though only temporarily, one goes beyond stratification. Thus, in vitro obviously creates families positively destabilizing existing discourses and norms, families that will always somehow become a record and a reflection of the space they got created within, telling much about the ‘condition’ of the human body/subject. Even if the culture and socius do its best to stratify everything, once more the message, I believe, still can be sent and received. In my opinion, such theories may be very empowering

⁴³ At the conference Nobody’s Child, Everybody’s Children at Malaspina University College, BC, Canada, May 24-26 , 2007 there were many voices (i.e. Mikki Morrissette, Freelancer Writer, Minneapolis, MN with the paper Redefining Family: The Role of Half-Siblings and ‘Birth Others’ in Donor-Conceived Lives ; Elizabeth Marquardt, PhD, Institute of American Values, New York City with the paper The Revolution in Parenthood: The Emerging Global Clash Between Adult Rights and Children’s Needs - An International Appeal from the Commission on Parenthood’s Future) stressing the hardships of the families where children were conceived due to the anonymous donation.

⁴⁴ For more on stratification please go to Gilles Deleuze and Felix Guattari (1987). *A Thousand Plateaus. Capitalism and Schizophrenia*, London and New York, Continuum.

for those who do not consider themselves a 'family' or feel 'worse' than others or uneasy precisely because of participating in human in vitro procedure. The cyborg from Haraway's A Cyborg Manifesto: Science, Technology, and Socialist-Feminism in the Late Twentieth Century (1991) as Scott Bukatman puts it "(...) *is not innocent; it was not born in a garden; it does not seek unitary identity* (...)"⁴⁵ (1997:73). "Father is dead, asshole" the female voice responds to the scientists who tries open the door by calling the system "Father" in Alien: Resurrection (1997) by Jean-Pierre Jeunet. The Schizo has no daddy and mommy as Mark Seem writes in the Introduction to Anti-oedipus. Capitalism and Schizophrenia (1983).

Conclusion

The becomings and deterritorializations, molecules and flows, intensities of different degrees of speed and slowness, the bodies are truly in love with them. The materiality of silently or not for that matter working organs, tissues and cells, brain's cells including, do play an important part in the life of the desire fueled embodied subjects. *Zoe* has decided to befriend the bodies and does not plan on changing her mind. 'Reality' constantly gets into the bodies with percepts and following them, affects, that will, as all has been incessantly 'stored-and-saved' in the 'memory banks'. The body is external, singular and unique, multiple and common, continually participating in forever shifting assemblages. Only such a realization, only such a perspective, as I have argued, allows more positive and adequate evaluation of IVF technique and practice. This level of comprehension also enables the proposition of more positive and accurate, as I have shown, approaches towards and concepts of human in vitro fertilization. Furthermore, one should never forget the assemblage-like 'nature' of IVF and the pregnancy and the post partum period when getting involved in the in vitro oriented debate. IVF technique and practice though certainly not 'milk and honey', do not have to be demonized and equated with negativity. On the contrary both the technique and practice can be evaluated as having to do with positivity, power (*potentia*) and production. They can also be conceptualized as the body's parts, imperceptible fragments, precepts, affects and the sources of the affected body's forces as well as tools for women to use and events they can participate in. In addition, the concept of in vitro as a stimulator and amplifier of

⁴⁵ Scott Bukatman, (1997). *Blade Runner*, London, British Film Institute, 73.

connections between female and male bodies which result in affects-emotions of love, might be suggested. As life is not about stillness, but motion and transformations which cannot necessarily be *a priori* predicted, then a non-approval means a decrease of flows, diminished production and prevention of some possible positive becomings and some interactions with others. Moreover, the suggested theories and manners of discussing IVF, recommended assessment, concepts and approaches together with the descriptions based on the empirical data gathered in the Netherlands and Poland, result in particular recommendations. The proposed manners, assessment, concepts, approaches and descriptions also result in important suggestions regarding feminist theory and men's studies theory.

CONCLUSION

To sum up my thesis I want to begin by saying that the territory, where the 'bodily', but also 'reproductive-productive-fertile-infertile-technologically-marked matrix', is located is not a very easy ground to walk. The morphology of human bodies and their particular situatedness do not always allow them to escape certain ideologies, beliefs, norms and discursive practices regarding those very bodies and subjectivities. Existing and circulating convictions, and expectations when it comes to the issues of reproduction, female and male bodies, but also sexualities, are not very much interested in major transformations and metamorphoses. For me it is very interesting to observe that, on the one hand, a life of the human body/subject is in fact all about becomings, affects, desiring-productions, precisely as Deleuze and Braidotti, among others, have written. On the other hand, there are still attempts to wrap and cover this body/subject with a huge 'molar blanket'. Constant metamorphoses and becomings of the human body/subject do occur on a daily basis. Even if it is located and exposed to the peculiarities of its location, it remains under the influence of existing cultural and social norms and beliefs. It never stays the same, enclosed in one and forever given frame of identity. It is desire fueled; it negotiates and changes; it is connective, external, perceptive, affective and singular; it is a 'zoe-body' that likes deterritorializations and is prone to rearranging the culturally and socially assigned functions and number of its very organs. Why then is there such an appearance of framing, labeling, naming and nailing down the affirmative flows and processes so intrinsic and inevitable to every human body/subject? It seems to me that the powerful body of the Deleuzian socius is still very much 'in charge' and what is enclosed and framed is always much easier to be controlled than flows and "immanent plateaus" of unexpected destinations and outcomes. And yet, it appears that the life of the human body/subject is precisely all about radical immanence happening on various, forever changing planes, between and within different assemblages of transformative and changeable characteristics.

Such a perspective on the human subject/body and life enables evaluation of certain phenomena the subject participates in. One of the major objectives of this dissertation is to try to understand human in vitro fertilization. It can be wondered if

anything can be truly understood and comprehended. However, with the proposed theories of approaching the human body/subject in addition to the introduced manners of discussing IVF (as a situated practice, a part of a longer procedure where a man is present and a changing assemblage possibly followed by the pregnancy and the post partum period which the human body is an element of) one may say one gets closer to the understanding of this contemporary phenomenon. Furthermore, in my opinion, the 'doing' of IVF can be actually assessed as an ethical activity and IVF itself as an ethical procedure. I am aware that to talk about ethics, especially when it comes to new reproductive techniques, demands careful consideration and a balanced debate. I would like to explore those issues in more elaborated and detailed manner in other research settings. For now, I would only like to briefly indicate why the 'doing' of IVF and IVF itself can both be evaluated as ethical. As I have argued, the participation in in vitro is about desiring-production, precisely as in vitro itself is all about. The outcomes of both cannot be easily anticipated. What is more, the changing assemblages of the human bodies/subjects intertwined with the assemblages of IVF are about movement, action, becoming, connecting and creating, but also probing how far the bodies/subjects can actually go. For Deleuze, as Marks explains, "*Morality is a set of constraining rules that judge actions and intentions in relation to transcendent values of good and evil. Morality is a way of judging life whereas ethics is a way of assessing what we do in terms of ways of existing in the world. Ethics involves a creative commitment to maximizing connections, and of maximizing the powers that will expand the possibilities of life. (...) ethics (...) is inextricably linked with the notion of becoming. Morality implies that we judge ourselves and others on the basis of what we are and should be, whereas ethics implies that we do not yet know what we might become*" (2005:85). Thus if, as Deleuze and Braidotti suggest, ethics gets detached from morality, then the ethics should "*(...) make life light and active, and to create new values*" (Marks, 2005:85). "*The transcendent categories of Good and Evil can be abandoned in favour of 'good' and 'bad'. A 'good' individual seeks to make connections that increase her power to act, whilst at the same time not diminishing similar powers in others. The 'bad' individual does not organize her encounters in this way and either falls back into guilt and resentment, or relies on guile and violence*" (Marks 2005:86). If ethics 'promote' connections, maximize powers, "*make life light and active*", support

becoming, are about affirmation and “*plead(s) (...) for a sober form of lucidity that aims at sustainable transformations*” (Braidotti 2008:185), stand for “*(...) a geometry of how much bodies are capable of*” (Braidotti 2008:188) but also employ categories of ‘good’ and ‘bad’ (that are about increasing/decreasing one’s powers to act and connect) when assessing the actions of the human bodies/subjects, then it seems right to risk a statement that the ‘doing’ of IVF and IVF itself can be ethically accepted and assessed as ethical themselves. Furthermore, when it comes to the understanding of IVF, I can recommend remaining very critical in building one’s comprehension of this advanced technique and practice based on the visual representations of it that are circulating in the visual media such as Internet. As proved in this dissertation, even if the visual can be very informative, it can also be very limited and thus not provide one with all the dimensions of this medical procedure. I am aware that IVF is not only represented in the form of photographic-like images on Internet. There are many documentary movies that address in vitro from various perspectives and in different manners. However, how it is done and what message is eventually sent to an audience require further investigation, which is not an objective of this thesis yet is worth doing in another study. I can also say that those ‘populating’ visual studies should emphasize a need for more complete representations of IVF, and discuss how those representations should look and what kind of message they should deliver. Furthermore, the adequate and balanced assessment of, conceptualizations of and approaches to IVF (thus deeper understanding of in vitro) delivered due to the proposed theories and manners of discussing this phenomenon allow undermining the correctness of the radical feminists’ and the Vatican’s arguments concerning IVF. In this sense, I can remain affirmative, hoping that their impact on people’s negotiations and attitudes when it comes to reproduction, ‘reproductive-productive’ female and male bodies, sexualities and technologies may decrease. In my thesis I have emphasized the impact of the Vatican. I have not discussed the influence of the radical feminists very much, though I would like to investigate it in another research. This is because I know for certain that they may cause unnecessary anxieties for those opting for IVF. I will not forget one of the interviewed women saying how difficult it was for her to negotiate between the radical feminists’ assessment of in vitro and her desire to have a child with the help of reproductive techniques/practices. The adequate and balanced

assessment/concepts/approaches concerning IVF can also be used in feminist's circles in order, to paraphrase, to help "women negotiate the transition to high-tech motherhood" and to close the gap "between "real" women-and particularly "sterile" women who seek biomedical help to reproduce-and the feminists who criticize biotechnologies".

The proposed theories concerning the human body/subject and the manners of discussing in vitro supported with the empirical data together with the delivered assessment/concepts/approaches to IVF result in recommending the best ways of managing it. The problems with fertility will not get miraculously solved overnight and so the existence of reproductive techniques/practices will not disappear either. Of course, I want to say that more research should be done on how to prevent infertility and how to 'solve' it without spending much money on assisted reproduction. However, because technological assistance is usually a business-like enterprise with certain pitfalls and dangers, one needs to be aware that fertility-infertility research may remain limited, and at the same time, try to advocate the best ways of managing 'what' exists here and now. As I have argued and explained the best would be to make IVF the most 'friendly' and, above all, safe for its prospective recipients. In my view, it is only the matter of having IVF practice properly organized (monitored, controlled, reimbursed, well-explained to society together with the issues of female and male infertility) that it may be of help for those with 'a wish for a child' but at the same time, not serve the patriarchal ideologies of reproduction and obligatory heterosexuality. Furthermore, it is crucial to not call for a non-approval of IVF; to make the 'existence' of the socius and its 'nature', especially when it comes to the issues of human reproduction, visible to the public yet remain critical of the socius; to keep the content of proposed laws (regarding assisted reproduction), and those who write them under close scrutiny; to involve more people in decision making processes (regarding assisted reproduction). Therefore, those with influence such as the Vatican, the radical feminists, and those involved in gender and men's studies should incorporate the proposed recommendations. Instead of turning, someone's life into a possibly difficult experience (i.e. the Vatican) they can do much to positively and affirmatively charge

one's becomings in the contemporary world's landscapes (in this case reproductive landscapes).

The theories and manners of discussing IVF combined with the empirical data together with the delivered evaluation/concepts/approaches to human in vitro fertilization result in suggesting the optimal ways of using it to transform existing ideologies, cultural and social norms, beliefs and discourses concerning the matters of reproduction, fertility-infertility, female and male bodies and sexualities, as well as, the advanced reproductive technologies themselves. IVF technology and practice can be used by feminists and those doing men's studies to argue that female and male bodies are not per definition 'reproductively fit' and chained to reproduction, but also to make infertility lose its mark of mystery, ambiguity and disability. The radical feminists and scholars of gender and men's studies can have theories 'based on IVF' (to recall a few) to emphasize that motherhood/fatherhood/parenthood is only an option, a possibility; motherhood does not have to be defined as a destiny or a burden, but as an affirmative desiring-production, an expression of natal powers and *potentia*; man can be seen as being much more interested in reproduction than 'production' and much more 'child-oriented' than society thinks; emotions-affects are intrinsic to both women/female bodies and men/male bodies; love and pleasure can be expressed by other organs and not necessarily the vagina and penis; reproduction becomes a set of assemblages of unknown *a priori* outcomes and the dynamic encounters and becomings occurring in those assemblages make it difficult to talk about the domination of any side over the other; the techno and the organic worlds blend, creating the space of difference and of becoming/production; there is no distinction between mind and body and so the human is, and has always been, an undivided unity, yet, this unity is at the same time a non-unity in the sense that it expresses the externality, thus the radical inhuman difference of the human/body; life is a positive and affirmative process and female and male bodies are equally positive and affirmative entities; family expresses the space of difference and de-stratification becoming all about desiring-production, affects, affirmative actions and engagement with all the possible others the technological others including. With these theories the radical feminist and those who deal with gender and men's studies can undermine circulating ideologies, norms, and discourses, thus help people in 'reproductive age'

and, especially people facing reproductive difficulties. IVF, instead of being all about negativity, can become an indicator of positivity. It can make one aware, to repeat it briefly, of the creation of a space of a radical difference, becoming and production when the interactions with all the possible others take place. Thus, it can become an eye opener pointing towards, among others, an inhuman and non-unitary position of the human body/subject, the ability of different organs to generate pleasure and love or a man's attachment to the body and not only to the mind. As such, IVF can be a powerful 'ally' due to its possible 'deconstructive' powers. It can be employed for feminist and men's studies' goals. As a matter of fact, the method and the practice of IVF can work very well against the established norms, practices, myths and ideological beliefs surrounding human reproduction, human bodies and sexualities which fits very well into the feminist and men's studies' agendas. The social order and totalizing discourses Foucault exposes, the symbolic and the "name-of-the-father" Lacan talks about, the socius of Deleuze and culture always seem to know much, much better. Yet those who look deeper will only see molecules, flows and "intensities of different degrees of speed and slowness" as Braidotti would say. One only needs better lenses to do so. Human in vitro fertilization, in my opinion, can serve as one. In this sense, again, IVF can be taken for an 'ally' without many fears. Precisely because, as I have already pointed out, it is an 'ally' with its abilities to diminish contemporary anxieties (regarding technology) as well as destabilize the well known and the 'commonly' believed in, enclosed in the body of socius, ideologies, norms, convictions and beliefs. What then will happen to this 'body'? Maybe it will become a flow itself.

'New reproductive assemblages' that is spaces where interactions between women/bodies and men/bodies occur as well as between them, fertility doctors and advanced reproductive techniques/practices, confirm the immanent and generative 'nature' of human life. 'New reproductive assemblages' stand for the spaces where each and every element of the assemblage undergoes constant becomings and deterritorializations and objects to harmful borders of assigned identities. 'New reproductive assemblages' are material and semiotic in a sense that everything that occurs there is "real" and yet can be used theoretically to transform existing ideologies, cultural and social norms, beliefs and discourses concerning the matters

of reproduction, fertility-infertility, female and male bodies and sexualities, as well as, the advanced reproductive technologies themselves. 'New reproductive assemblages' are 'new' because technology has been introduced to the 'reproductive tango'. They are 'new' because one may observe deterritorializations of well-known and 'old' elements. Yet, these assemblages are, in a sense, 'old'. They are 'old' precisely due to the 'old' elements (doctors, women/female and man/male bodies) they consist of and the 'old' theme (reproduction). This 'new'-'old' blend of 'reproductive assemblages' is something to consider by those familiar with Deleuze's philosophy. Definitively, it is good to become involved in the processes/activities that will become a materialization of Deleuze's theories and concepts. However, those processes do not have to be all together new, sometimes it is enough to add one element (i.e. IVF toolbox) that will work as magnification, as lenses needed to realize that flows, deterritorializations, externality, affectivity and becoming accompany human actions. It is just the existence of 'molar blanket' that may impair one's vision.

In this dissertation, to remain faithful to my readers and do everything that I have promised in the Introduction, I have made a move from empirical-textual (Chapter One, Two and Three) to empirical-theoretical (Chapter Four and Five) part. I have also transformed this dissertation from more to less linear. Yet, though I have done my best to supervise the move and transformation planned, this dissertation has, in fact, become an assemblage itself. Every element of an assemblage influences the other. This thesis has become assemblage-like because in order to understand in vitro I have led a polemic with the radical feminists and the Vatican, which has been about proposing theories and manners of discussing IVF that would result in more adequate and balanced assessment/conceptualizations/approaches to it. On the other hand, the polemic has allowed undermining the correctness of the radical feminists and the Vatican's arguments concerning IVF. The adequate and balanced evaluation/concepts/approaches to in vitro have brought better comprehension of this phenomenon and at the same time they can be very useful for feminists as to assure the best future for feminist politics. The critical reading of the visual representations of IVF on Internet has allowed recommending to a viewer to be careful when her/his understanding of this phenomenon is based on its visual representations. The

proposition of the best ways of how to ‘go about’ in vitro and suggestions regarding theory of desire, feminist and men’s studies theories has, on the one hand, allowed talking about the best ways of managing and using the phenomenon, and on the other hand, possibly helping those in ‘reproductive age’. Elements, the assemblage consists of, are prone to spontaneous connections and following them productions. I have allowed this dissertation to take on the ‘assemblage’s’ shape in order to do justice to the profoundly complex issues of the present ‘reproductive-productive-fertile-infertile-technologically-marked matrix’. However, my supervision of occurring connections and their productions has always been exercised in order to navigate relatively safely and to bring my readers safe and well to the meta-line of the ‘journey’ commenced in Introduction.

Utrecht, September 2008.

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NEDERLANDSE SAMENVATTING [Summary in Dutch]

Menselijke in-vitrofertilisatie is datgene wat ook wel bekend staat als geassisteerde voortplanting of technologisch versterkte voortplanting. Wat hierbij vooral in het oog springt, is de creatie en verspreiding van, zoals ik het noem, ‘nieuwe reproductieve assemblages’. Deze ‘nieuwe reproductieve assemblages’ bestaan in de ruimte waar constante interactie tussen vrouwen/lichamen en mannen/lichamen plaatsvindt, naast de gelijktijdige interactie tussen deze mannen en vrouwen, fertiliteitartsen en geavanceerde reproductieve technieken en praktijken. Er zijn vele debatten en publicaties, vooral vanuit een feministisch standpunt, die kritiek uiten op het fenomeen van de menselijke voortplanting, het menselijk lichaam, ‘reproductieve’ (vrouwelijke) en ‘productieve’ (mannelijke) lichamen, kwesties inzake vruchtbaarheid en onvruchtbaarheid, nieuwe reproductieve technologieën, de kracht van bestaande ideologieën, sociale en culturele normen, overtuigingen en dialogen. Een breed scala aan onderwerpen en de discussie is nog lang niet beslist. Mijns inziens valt over al deze kwesties nog veel te zeggen, vooral wanneer het gaat over het verlengen of genereren van leven. Deze dissertatie is een bijdrage aan de aanhoudende discussie over ‘het lichaam’ en de, zogenaamde, ‘reproductieve-productieve-vruchtbare-onvruchtbare-technologisch-gekenmerkte matrix’. In die hoedanigheid behandelt deze dissertatie vraagstukken met betrekking tot vrouwelijke en mannelijke (reproductieve-productieve-vruchtbare-onvruchtbare) lichamen en seksualiteit. Het zet vraagtekens bij het begrijpen van wat in-vitro betekent, bediscussieert de beste manier om het fenomeen te beheren en het in te zetten om bestaande ideologieën, normen, overtuigingen en discussies over kwesties als reproductie, vruchtbaarheid-onvruchtbaarheid, vrouwelijke en mannelijke lichamen en seksualiteit en tevens de geavanceerde voortplantingstechnologieën zelf te transformeren. Met het oog op het aanspreken van zowel vrouwelijke en mannelijke (reproductieve-productieve-vruchtbare-onvruchtbare) lichamen en seksualiteit, het uitdagen van het begrijpen van in-vitro en het bediscussiëren van de beste manieren om deze techniek te beheren en gebruiken zal deze dissertatie ‘verworden’ tot het volgende:

Het 'verwordt' tot een polemiek tussen radicale feministen en het Vaticaan, het leidend orgaan van de katholieke kerk, over in-vitrofertilisatie. De polemiek ontstaat niet alleen door de tegengestelde ideeën over in-vitrofertilisatie die deze twee partijen aanhangen, alsook door de invloed die deze partijen hebben op de huidige ontwikkelingen en discussies op het gebied van IVF. Tegelijkertijd kunnen zij invloed uitoefenen op de publieke opinie omtrent geassisteerde voortplanting, de overwegingen die onvruchtbare stellen maken en de beslissingen die zij aan de hand daarvan nemen, maar ook op de wijze waarop IVF techniek wordt georganiseerd en uitgevoerd. Aangezien zij deze praktijken negatief beoordelen, kan hun krachtige invloed eveneens zeer negatieve gevolgen hebben. De polemiek maakt het ondernemen mogelijk, waar het gaat om de rechtvaardiging van de argumenten van de radicale feministen en het Vaticaan aangaande in-vitro. De polemiek laat ook zien dat de theorieën en discussiewijze met betrekking tot IVF, zoals aangewend door radicale feministen en het Vaticaan, debet zijn aan hun negatieve en inaccuraat beoordeling, beeldvorming en benadering van de techniek en praktijk van IVF. De polemiek bewijst dat andere theorieën en discussies over IVF kunnen resulteren in een veel nauwkeuriger en mogelijk zelfs veel minder negatieve evaluatie, beeldvorming en benadering van de techniek en praktijk van IVF. Deze dissertatie beoogt in die zin een theoretische oplossing voor ethische en praktische problemen met betrekking tot IVF te geven. De in overweging genomen theorieën zijn van toepassing op het menselijk thema en het menselijk lichaam en zijn eerder voorgelegd door wetenschappers als: Rosi Braidotti, Gilles Deleuze, Claire Colebrook, Elizabeth Grosz en Hannah Arendt. De voorgestelde wijze om IVF te bediscussiëren komt geheel voor rekening van de auteur, hoewel sommige manieren om in vitro te bespreken gebaseerd zijn op aanwijzingen van Ann Rudinow Saetnan en, nogmaals, op de theorieën van Gilles Deleuze. De theorieën zijn toegepast in empirisch onderzoek met hulp van zowel Nederlandse als Poolse IVF stellen. Het empirisch onderzoek helpt bewijzen dat de voorgestelde wijze om IVF te bediscussiëren wel degelijk in de 'realiteit gereflecteerd' wordt.

Deze dissertatie 'verwordt' behalve een polemiek vooral een voorstel om de afwijzing of kritiekloze bewondering van IVF om te zetten in evenwichtige beeldvorming, beoordeling en benadering van dit fenomeen. Aangezien de IVF

technologie niet zal verdwijnen en ook vruchtbaarheidsproblemen niet in een vloed en een zucht opgelost zullen worden, kan deze harmonieuze benadering helpen de valkuilen en risico's met betrekking tot IVF te beperken. Accuraat en uitgebalanceerd beoordelen, benaderen en conceptualiseren vindt een warm onthaal in de meeste wetenschappelijke onderzoeksgebieden, vooral in feministische kringen. Dit is voornamelijk vanwege de noodzaak de best mogelijke toekomst voor feministische principes te waarborgen. Door te 'verworden' tot een voorstel voor evenwichtige evaluatie, conceptualisatie en benadering tracht dit proefschrift feministen een 'hulpmiddel' te geven bij het ondersteunen van "vrouwen die de overgang naar high-tech moederschap overwegen" en het gat te sluiten "tussen 'echte' vrouwen en 'steriele' vrouwen die bio-medische hulp zoeken om zich voort te planten- en de feministen die deze biotechnologie bekritisieren".

Tevens 'verwordt' deze dissertatie een voorstel voor specifieke aanbevelingen aan het Vaticaan, radicale feministen en gender-en mannenstudies betreffende de beste manier om in-vitrofertilisatie te beheren. Het laat zien hoe grof en onvoorzichtig de techniek en praktijk van IVF in bijvoorbeeld Polen lijkt te worden omdat het Vaticaan zich negatief blijft opstellen en reproductieve technologische ontwikkelingen blijft verwerpen. Daarnaast beschrijft het de 'relatief optimale' manier waarop de techniek en praktijk van IVF in Nederland functioneert. In deze dissertatie zijn ook suggesties opgenomen betreffende theorieën van verlangen en theorieën die voortkomen uit gender- en mannenstudies, die gebruikt kunnen worden om bestaande ideologieën, culturele en sociale normen, overtuigingen en discussies aangaande voortplanting, vruchtbaarheid-onvruchtbaarheid, vrouwelijke en mannelijke lichamen en seksualiteit en ook de geavanceerde technologie zelf aan het wankelen te brengen. Het is verstandig te beginnen met het geven van aanbevelingen alvorens tot actie over te gaan, hoewel zowel de aanbeveling van bepaalde theorieën alsook de actie die daaruit kan volgen, een hulpmiddel kan bieden aan mannen en vrouwen 'op een vruchtbare leeftijd', die kampen met vruchtbaarheidsproblemen en aan de hand van deze theorieën en acties beslissen of zij deel willen nemen aan een IVF behandeling.

Uiteindelijk ‘verwordt’ deze dissertatie tot een kritische interpretatie van de zichtbare representatie van menselijke in-vitrofertilisatie. Hierin wordt bediscussieerd welk beeld van in-vitrofertilisatie opdoemt wanneer het als beeldmateriaal op het Internet wordt weergegeven. Ook wordt getracht na te gaan waarom bepaalde visuele representaties, en dus beeldvorming van IVF, eigenlijk hebben kunnen ontstaan. Tevens wordt getracht in kaart te brengen hoe betrouwbaar de huidige visuele representaties zijn en of het publiek wat deze representaties bekijkt (om een duidelijk beeld te krijgen aangaande beoordeling, benadering en beeldvorming van menselijke in-vitrofertilisatie) er goed aan doet deze hedendaagse informatiebron als uitgangspunt te nemen.

In een zin samengevat, beschrijft deze dissertatie een ‘reis’ door een ‘lichamelijke’ en tegelijkertijd ‘reproductieve-productieve-vruchtbare-onvruchtbare-technologisch-gekenmerkte matrix’.