

# **Fertility treatment and organisational discourses of the non-reproductive female body**

## **Abstract**

This paper contributes to debates on the intersections between organisations, the body and reproduction by exploring how the non-reproductive female body is discursively (re)constructed by organisations which provide fertility treatment, such as private clinics and fertility magazines. Organisation studies has neglected the non-reproductive body, despite a fair amount of research on its reproductive counterpart, especially pregnant and maternal bodies. Equally, these discussions privilege the employment relationship – e.g., how women are enjoined to manage their bodies at work – whereas we concentrate on the marketplace, or the field of fertility treatment, and the organisations therein. These organisations, while focused on reproducing bodies, also influence, compound, and challenge notions of the bodies they are involved with. Through a Critical Discourse Analysis of texts produced by UK fertility organisations, we present three discourses of the non-reproductive female body that (re)generate subject positions where the absence of reproduction is a medical condition, an emotionally distressing experience, and something that needs to be cared for. Our argument suggests how the texts can operate as a form of Foucauldian governmental biopower, emphasising how they hail the infertile female subject.

**Keywords:** biopower, Critical Discourse Analysis, body, fertility treatment, Foucault, infertility, hailing, organisations, reproduction

## 1. INTRODUCTION

In this paper we examine how UK organisations involved in fertility treatment position women's bodies in relation to reproduction<sup>1</sup> in order to contribute to understandings of the social construction of womanhood and motherhood. Our analysis centres around texts produced by these organisations, exploring how they (re)construct discourses of the non-reproductive female body. We depart from the Organisation Studies (hereafter OS) focus on workers' bodies, instead investigating how fertility organisations hail their (potential) customers. We understand organisational texts as (re)producing subject positions imbued in power relations, and employ Critical Discourse Analysis (CDA) to track the emergence of three discourses - the medical body, the emotional body, and the cared for and caring body – and their interrelations.

First we outline our theoretical framework: Foucault's (1978, 1980, Foucault & Blasius, 1993) conceptualisations of governmentality and biopower, which target both whole populations and individuals. We then review OS literature on bodies and reproduction, noting the absence of studies exploring the infertile body. This silence is significant, because the lack of reproduction and the presence of fertility issues are both inherent parts of our reproductive lives and life stages. A woman's ability to decide to become or not to become a mother, and whether this decision can safely be enacted within our societies, is a longstanding question in feminist studies of bodies, reproduction, and agency (Firestone, 1970; Pfeffer, 1993; Rich, 1976). However, even within these debates, very little attention has been paid to the organisational landscape that shapes

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<sup>1</sup> Because of the overwhelming cisnormativity in the field of fertility treatment, our discussion focuses on cis women's bodies. Transgender and gender non-conforming people's bodies currently do not feature in this field.

this ability to decide on our reproductive lives, and indeed our understanding of what it means to be (in)fertile *per se*. What concerns us here is how various bodily subject positions are created and offered by the relevant organisational texts, and how Foucauldian governmentality is imbricated in these positions.

Next we present the context around fertility treatment, noting how the organisational presence in this field was for the most part not a matter of public debate until the birth of Louise Brown, the first In-Vitro Fertilisation (IVF) baby, in 1978. This caused a public outcry and brought the UK government to intervene by creating a governing body, the Human Fertility and Embryology Authority (HFEA). Nowadays fertility treatment is a heterogeneous field comprised of many different types of organisations. We continue by outlining our methodology, a critical Foucauldian take on discourse analysis. Data were gathered in 2013 and 2014 at the Fertility Show, a biannual event taking place in London and Manchester aimed at people who are trying to conceive. After this, we discuss our findings, showing how the non-reproductive female body is understood in the relevant discourses as medically malfunctioning, as emotional, and as something to be cared for by the plethora of organisations in the field and/ or to care for itself. The presence of these discourses suggests how, through their texts, these organisations can shape, exacerbate, and even question our notions of what a non-reproductive female body should be or feel like. We see these findings as instances of biopower and governmentality, in that organisational discourses of non-reproduction (re)produce subject positions that are simultaneously to-be-governed by fertility organisations and expected to self-govern. This, in turn, hails the infertile subject as both medicalised and emotional, expected to relinquish agency to the organisations who will provide them with services and products to enable them to biologically

reproduce, but also to take the necessary steps to maximise their chances of this happening.

## **2. BIOPOWER, BODIES, AND GOVERNMENTALITY**

Our focus on part of the organisational landscape surrounding reproductive choice is grounded in the Foucauldian approach that sees biopower, knowledge, and bodies as situated in a continuum of governing practices and techniques referred to as governmentality (Foucault, 1980). Writing on Foucault, Deleuze (1986, p.83) notes that power “in relation to knowledge... produces truth, in so far as it makes us see and speak”. In line with this approach, our analysis centres on the organisational environment that (re)constructs particular subject positions while simultaneously being infused with power relations.

These subject positions are embedded in a biopolitics which demands that the population is both productive and reproductive (Phelan, 1990). Biopolitics is “the administration of bodies and the calculated management of life” (Foucault, 1978, p.140) and is closely linked to Foucault’s notion of government as the meeting point of self-governing practices with government from without (Foucault & Blasius, 1993). Specifically, biopower aims at “optimizing forces, aptitudes, and life in general without at the same time making them more difficult to govern” (Foucault, 1978, p.141). Its aim is the conduct of conduct, of populations at the macro level but also of each of us as individuals at the micro level. Accordingly, we present the artefacts from the Fertility Show in our data set as biopolitical enjoiners to those who interact with them to understand themselves and their bodies through the messages presented.

As such, we read discourses on sex and, in the case of our research, reproduction, as "the sign of a particular organization of the (personal and political) body" (Phelan, 1990, p.426). They are simultaneously entangled with individual bodily discipline and the regulation of populations. This entanglement produces "infinitesimal surveillances, permanent controls, extremely meticulous ordering of spaces, indeterminate medical or psychological examinations, ... an entire micro-power concerned with the body" (Foucault, 1978, p. 146). We approach the organisation of (non)reproduction as inherently political within this view of the biopolitical foundation of life.

### **3. BODIES, NON-REPRODUCTION AND ORGANISATIONS: BEYOND FERTILITY**

OS has paid considerable attention to the body at work, women's bodies in the workplace, and the interactions and intersections of production and reproduction more broadly (e.g., Brunner & Dever, 2014; Harding, 2002; Hassard, Holliday & Willmott, 2000; Hockey & Allen-Collinson, 2009; Hope, 2011; Trethewey, 1999; Wolkowitz, 2006). In recent years scholars have stressed the importance of surfacing women's reproductive life stages within and despite the organisational setting where they may be experienced (Gatrell, Cooper & Kossek, 2017). These discussions focus on menstruation (e.g., Grandey, Gabriel & King, 2020; Sayers & Jones, 2015); pregnancy and maternity (e.g. Fox & Quinn, 2015; Gatrell, 2019; Grandey et al., 2020; van Amsterdam, 2015); birth (Huopalainen & Satama, 2019); miscarriage (Boncori & Smith, 2019; Porschitz & Siler, 2017); and (post-)menopause (e.g. Atkinson, Beck, Brewis, Davies & Duberley, 2020; Grandey et al., 2020; Jack, Riach & Bariola, 2019). The most prevalent foci are the pregnant body and the maternal body.

This literature asserts that the ideal worker is assigned male at birth, rational and in control, with emotions, instincts and bodily functions suppressed at all times. Equally, their body is not beholden to any demands from non-work life, especially when at work – organisational expectations should come first. As such the perfect organisational body is also childless. There are several examples of how women manage their bodies in this regard, including concealing pregnancy-related nausea, training so breastmilk is only produced outside working hours and abjuring motherhood altogether (Gatrell et al. 2017; Hunter & Kivinen, 2016). Still, resistance to these enjoinders is also identified, like one senior manager who openly breastfed her baby during meetings (Gatrell, 2013).

These arguments provide an important lens on women's lived embodiment in organisations. However, despite its arguments around (the performance of) childlessness and nascent discussions of miscarriage, this literature pays no attention to infertility. Moreover, it deals with how female bodies are managed and experienced in the workplace context. In contrast, our argument investigates the marketplace for fertility treatment, the texts produced by its organisational members and their potential subjectifying effects. As such, more relevant for our purposes here is the considerable and longer standing debate in other disciplines focused on whether the involvement of modern science in reproductive health, inevitably infused with contemporary cultural, social and gender norms (Gallagher & Laqueur, 1989; Harding, 1991), should be seen as an intrusion turning women's bodies into 'mother machines' (Corea, 1986; Martin, 1989; Oakley, 1984; Rowland, 1985; Williams, 1997) or a liberating force able to restore women's bodily agency (Firestone, 1970). Within the context of the

treatment of infertility, this debate expanded into society more broadly and became especially fraught in the UK after the birth of Louise Brown.

Moreover, and despite the significant scientific, social, and political advances during the 20<sup>th</sup> century, issues around reproductive health, choice, and their intertwinement with the market are still highly relevant today. These developments have granted some women, in the Global North especially, a range of contraception and reproductive technologies to prevent, end or facilitate pregnancy. Most recently there have been legal changes which relax previous bans on abortions in Ireland and Northern Ireland (Connolly, 2019; McDonald, Graham-Harrison & Baker, 2018). But, at the same time, the rise of populist politics makes the choice of motherhood an increasingly sensitive one worldwide: like Donald Trump's decision to block US funding of the United Nations Population Fund (Klasing, 2018; Terkel & Bassett, 2017); increasing picketing outside UK clinics that perform abortions (Lowe & Hayes, 2019); the growing number of conscientious objections to perform abortions from clinical staff across Europe (European Data Journalism Network, 2019; Lalli, 2016); and the (attempted) outlawing of abortion in several US states (BBC News, 2019, 2021).

All of this is increasingly mediated by organisations that walk the line between society and the marketplace: from governmental institutions and organisations regulating fertility treatments and medical procedures to private clinics, support groups, and businesses focusing on women's reproductive choices. These actors cater to an expanding market: the HFEA (2018) suggest that fertility treatment cycles rose by 12% and egg and embryo freezing by 523% between 2013 and 2018 in the UK. Equally, only 35% of IVF was NHS-funded in 2018, indicating the significant costs for many

going through this process. These figures are also indicative of the growth in demand for fertility services despite counter-trends including women deciding not to have children for environmental reasons (Fleming, 2018; Hunt, 2019). Importantly, we are not suggesting that persistent infertility and the long term suffering it can entail are simply discursive artefacts of this marketplace. Neither do we argue that the advice given in the texts we analyse – an example being improving sperm quality via good nutrition - is medically unsound or empirically inaccurate. And we are not claiming that how these texts (re)construct women’s bodies is unique to the field we explore. Instead our interest is in how the texts hail their consumers by offering them specific sorts of subject positions – in the example above, as self-caring bodies. As such, these organisations generate a constellation of services, products, discourses, and practices that can intervene in our understandings and absence of motherhood. The non-reproductive female body is also not a body which is necessarily clinically infertile. It *can* be, but fertility treatment caters to women who may be socially as opposed to/ as well as medically infertile: single women, women in same-gender couples, and ‘older’ women (HFEA, 2018).

OS scholars have analysed the role of discourse in constructing social understandings of norms, roles, and in granting, consolidating or damaging an organisation’s legitimacy (e.g., Vaara, Tienari & Laurila, 2006). Here we take their cue to examine how discourse shapes understandings of the non-reproductive female body, to explore the power effects that this might engender. If infertility and non-motherhood are ‘problematic conditions’ for women, then the abundant organisational presence in the field arguably points towards the underlying discourses that gave shape to the path



which led us here. As such, we ask *How do organisations involved in fertility treatment discursively construct the non-reproductive female body? What are the implications?*

From this perspective, bodies are constantly (re)constructed through changing power dynamics. Power manifests through and on to the subjective and collective body (Foucault, 1980), so the (re)production of what is 'normal' and what is not, of what is a 'good' body and what is not, are inseparable. The mediation of organisations in this process becomes relevant when we consider how it can influence our understandings of this inseparability. As such, organisations cannot be anything other than inherently (bio)political, as are the discourses evoked within the texts they produce. These organisations exist precisely because certain notions of the non-reproductive female body exist; and, by existing, they influence, compound, and may even challenge such notions.

#### **4. FERTILITY TREATMENT IN THE UK AND THE FERTILITY SHOW**

This field has slowly but steadily emerged throughout the past 150 years, primarily due to two developments: reproductive medicine and birth control in the late 1800s and early 1900s, and the birth of obstetrics and gynaecology in the mid 1900s (Pfeffer, 1993). The relevant socio-political environment acknowledged women's bodies in medicine largely only when fertile or pregnant, and, importantly, as bodies that ought to become pregnant and give birth once married (Pfeffer, 1987). This was particularly evident in the role played by Marie Stopes in the creation of the first UK birth control clinics, and her later association with feminist groups to advocate reproductive health

within marriage (Cohen, 1993; Pfeffer, 1993; Soloway, 1995; Stopes, 1921). Fertility treatment followed as a series of interventions in the 1950s.

The clinic where Louise Brown's birth took place, the Oldham clinic in Lancashire, documents how their treatments were initially addressed towards women whose families were often unaware of their attempts at pregnancy (Elder & Johnson, 2015a, 2015b, 2015c; Johnson & Elder, 2015). Infertility, put simply, was not very discursively visible in the UK until the late 1970s. Public concern mostly emerged after Louise Brown's heavily documented birth on the 25<sup>th</sup> July 1978, which milestone caused strong reactions from UK society, pushing the government to intervene (see Becker & Becker, 1992; Iglesias, 1984; Association of Lawyers for the Defence of the Unborn, 1984). First, a committee chaired by moral philosopher Mary Warnock was constituted in 1984, tasked with making recommendations on the ethics of IVF and reproductive medicine (Department of Health and Social Security, 1984). As a result, the HFEA was established in 1990 as the national regulator of fertility treatment and research. It now provides licenses to UK clinics as well as information and support to prospective and current patients. The development of fertility treatment also signals how, until 1990, very little regulation existed regarding the private healthcare sector and its practice of reproductive medicine in the UK: it operated for several decades with minimal societal scrutiny (Pfeffer, 1993).

Today the fertility industry is bigger than ever, as indicated in section 3. Its organisational landscape is also very diverse: it contains public and private clinics; institutional organisations; non-profit organisations; patient support groups; and a plethora of other businesses seemingly catering to any health, social, legal and holistic

demand the non-reproductive market may present. The burgeoning of the industry is also the conditions of possibility for as well as a partial outcome of the Fertility Show, a biannual event taking place in London and Manchester which is “for people who need information and advice on their fertility” (The Fertility Show, 2019). Here organisations involved in fertility treatment, information, and support meet people who are trying to conceive. Seminars are also given by experts, with topics ranging from explanations of infertility and treatments to support, adoption, and alternative health approaches. Overall, the Show aims to provide prospective patients with all the information they might need before, during, and after treatment.

Fertility treatment and the Show in particular provide an illuminating setting when analysing organisations and bodies. Not only do the organisations taking part in the Show often physically intervene in existing bodies in order to create new ones, but at the event, at a specific time and in a specific place, these organisations disseminate the texts they produce to the people who are meant to consume them as well as being the bodies to be made reproductive. The single woman, the lesbian couple, the ‘older’ woman, and the infertile heterosexual couple can all meet and talk to the experts and the organisations who make infertility their business, literally or figuratively.

## **5. CRITICAL DISCOURSE ANALYSIS**

To investigate how UK fertility treatment organisations discursively represent, hail and thus (re)produce various positionings of the non-reproductive female body, Author A undertook a Critical Discourse Analysis (CDA) of organisational texts collected at the Fertility Show. Data were gathered in the form of 170 booklets and leaflets and 8

seminar observations at the London Show in 2013 and 2014<sup>2</sup>. The texts were provided by the government; 12 private clinics; 9 NGOs; 2 NHS Foundation Trusts; 1 professional association; and 12 other businesses. In our analysis, we use the term 'prospective patient' to indicate the non-reproductive female body, as women consuming organisational texts disseminated at the Fertility Show all fall into this category – either as receivers of services and products, or as donors.

Due to the many approaches to Discourse Analysis (DA), the notion of discourse can be “essentially fuzzy” (Van Dijk, 1997, p.1). The analytical approach we take is based on Fairclough’s (1989, 1992) early work on CDA, and adopts a substantially Foucauldian perspective. Foucault defines discourses as “practices which form the objects of which they speak” (1972, p. 49). What we say and write are understood as manifestations of discourses which (re)construct social phenomena. CDA distinguishes itself from DA due to its concern with how discourse reproduces or challenges unequal power relations (Van Dijk, 2015). Language in CDA is thus understood as social practice (Burr, 2003; Fairclough, 1989; Fairclough & Wodak, 1997) and a vehicle for power which sustains and organises social life (Wodak & Meyer, 2009).

Fairclough’s (1989, 1992, 1995a, 1995b) approach analyses discourse on three levels: text analysis, discursive practice, and social practice. This process is only suggested: depending on the research context and questions, analysts can be flexible in their approach. In line with our empirical aim, our analysis is confined to the first level,

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<sup>2</sup> Having recently checked the websites of some of the organisations who attended these Shows, we have concluded that the language they used in their propositions to potential customers then has changed very little in the intervening period.

because we seek to understand which discourses are (re)produced within the organisational texts analysed. Such analysis deals with small units like voice, participants, and transitivity in grammar, but also wording. It allows for discursive constructions to emerge, being carried out to understand how something is being talked about through the use of specific grammatical elements. We utilise it to understand which discourses fertility organisations draw upon when talking about the female body in their texts.

An important element of this level of analysis is nominalisations. These entail “the conversion of processes into nominals, which has the effect of backgrounding the process itself... so that who is doing what to whom is left implicit” (Fairclough, 1992, p.179). For example, the term ‘fertility treatment’ can itself be seen as a nominalisation: it includes a number of procedures (testing, evaluating, operations, and so forth), done by a variety of people and organisations that remain, within this nominalisation, unnamed yet inherently present (the doctor, the counsellor, the nurse, the clinic etc.). As Fairclough (1992, p. 27) notes, nominalisations allow for the “systematic mystification of agency” and for “the agent of a clause to be deleted”.

Data were coded following Gioia, Corley and Hamilton’s (2012) approach to qualitative data analysis. At the first level of coding, the focus was on identifying the main terms related to the body and their frequency. Fertility treatment organisations act on a cis woman’s body with the aim of creating or completing her family through medical and non-medical procedures (i.e., by being a patient). In this first step, a number of categories were identified for each term looked for. In the second level of coding, the analysis was narrowed to thematic groups based on frequency of use, similarities, and

the interpretation of such categories. This formed the basis of the third level of coding, where these emerging discursive constructions were grouped into three main discourses. Table 1 summarises these discourses, the constructions they hinge on and the key grammatical elements which constitute them.

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Table 1 about here

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## **6. EMERGING DISCOURSES, CONSTRUCTIONS AND SUBJECT POSITIONS**

As Table 1 exemplifies, the three discourses on the non-reproductive female body are as follows. The medical body is comprised of the discursive constructions of the animal body and the examined body; the emotional body of the distressed body and the successful body; and the cared for and caring body of the passive body, the self-caring body, and the in control body. We discuss their interrelations in section 7.

### **6.1 The medical body**

The discursive constructions that make up the medical body (re)construct it as an object of the medical gaze, whether by virtue of its animal characteristics or its being an object of science to be healed, examined, or modified.

### 6.1.1 The animal body

Here, the prospective patient's body is understood in its primordial animal features rather than anything specifically human. Examples of the emergence of the discursive construction of the animal body in the texts include:

"...just before the eggs *are harvested*" (Fertility magazine<sup>3</sup>).

"In conventional IVF, a large number of sperm are *placed* with each egg, so that the sperm *compete 'naturally' to fertilise the egg*" (Private clinic booklet).

"Excess good quality embryos can be vitrified (frozen) for a subsequent transfer, but *not all embryos will merit freezing as only good quality embryos are likely to survive* the defrosting process and *give a reasonable chance of pregnancy*" (Private clinic booklet).

These examples show a construction of human body parts – eggs being harvested, sperm being placed to compete to fertilise an egg, selection of embryos for vitrification - that is reminiscent of how veterinary medicine discusses non-human animal reproduction. See for example these excerpts from Gordon's *Controlled Reproduction in Cattle and Buffaloes* (1996):

"It is believed that the sperm reservoir could serve to reduce the risk of polyspermy [where an egg is fertilised by more than one sperm] while ensuring that sufficient sperm are available in the oviduct when ovulation does occur; it may also provide a favourable microenvironment for sperm survival" (p.13).

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<sup>3</sup> All italics in quotations are our emphases.

“Before it reaches the blastocyst [pre-embryonic] stage, and despite cell division, the embryo shows no increase in volume or protein content. At the blastocyst stage, true growth commences with rapid cell division and differentiation. Embryo size and protein content increase markedly between hatching at day 8 or 9 and day 16” (p.16).

Here the words used to refer to the infertile human body undergoing treatment are similar to those used to describe non-human animal bodies undergoing veterinary treatment. Whereas the processes of fertilisation can be argued to be very similar, the environment, justification, and context are very different. Cattle are bred on farms, mostly to sustain the food industry; within fertility treatment, the woman is fertilised in a clinic for social purposes related to motherhood. This is not to say non-human animals are inferior to human animals and therefore that similar terminology cannot be used for both types of assisted reproduction. Instead, we are arguing that the subject positions created within these Fertility Show texts reduce human bodies to little more than their parts, just as happens to cattle’s eggs, sperm and embryos in Gordon (1996).

Another element connecting these types of assisted reproduction is that in both human and non-human animal bodies are constructed discursively by hiding or removing the agent in a sentence. The vet is absent in Gordon, just as clinical fertility experts are absent in the texts from the Fertility Show. In the latter, the nominalisations used imply that it is not you-as-patient going through fertilisation, but the egg; and, even if we know that there will be someone (a doctor or a nurse) carrying out the procedure, these texts do not mention them explicitly. Instead they focus on body parts as passive



recipients of procedures. Examples of nominalisations include assisted hatching, male factor infertility, fertilisation, vitrification (freezing) of gametes (eggs and sperm) and embryos, insemination of eggs, assisted conception, survival of the eggs, egg collection, egg freezing, semen assessment and embryo transfer.

All these nominalisations also reduce processes entailing different stages of bodily intervention to a single term, thereby reducing the multiple steps the experts (here, the embryologists) have to take. This contributes to the (re)construction of the animal body as follows. First, the nominalisations are also true for other mammals' fertilisation; second, by focusing on parts of the body that need intervention rather than on the individual being treated, or even their whole body, organisations locate fertility issues inside parts of the patient while observing them from a detached position. If anything is not working correctly, then, it is not *you*: it is *a part* of you, and this part can be corrected, removed, enhanced, or examined. Third, these reductive nominalisations relegate any sense of the lived experience of fertility treatment to the background.

In sum, discursively constructing the female body as animal suggests a reductive approach to (in)fertility. Here, if the body is understood as animal (i.e., not specifically human), the cause of fertility issues is located in biology rather than in the person and their lived experience.

### **6.1.2 The examined body**

The examined body is a body that exists under the medical gaze: it needs to be closely looked at. This construction suggests not only that the body is there in order to be

thoroughly examined but also that, in this maze of tests, medical histories, and investigations, the patient will mostly be passive. Examples include:

“The medications also *control* the time you will release the eggs, *enabling the scheduling* of sexual intercourse, IUI (Intrauterine Insemination) or IVF procedures at the *optimal time* to achieve pregnancy” (Private clinic booklet).

“Time-lapse system allows us to *constantly monitor* the embryos ... takes photographs ... allows the embryologist to *observe* key events ... which assist the embryologist in *selecting* the best embryo for transfer” (Professional association leaflet).

The active agents here are doctors and examinable body parts. The examined body is scrutinised (constantly monitored) and receives treatments (medications control egg release) rather than being the active participant in the sentence.

Because this construction is based on the presence of a medical gaze, a number of nominalisations are present: fertilisation, embryo transfer, In Vitro Maturation, blastocyst transfer, intrauterine insemination and Uterine Cavity Assessment. It is perhaps unsurprising to see nominalisations more often in this discursive construction than in others, as nominalisations collapse a process into a singular moment. As with the animal body, the many steps involved in the processes of, say, embryo transfer are concentrated into one. This use of nominalisation hides the broader (re)construction of the examined body, and again conceals the fact that this body is examined more often than the texts seem to indicate. Common key words in this discursive construction are investigation, treatment, to establish, test, undergo,

diagnose, monitor, check, scan, collect, and select. These actions are performed on the body in order to examine it, but the emphasis is on the performed action, not the agent.

To summarise, a body that is constructed as examined implies the justification of forms of intervention through ever-newer tests, drugs, and technologies. Fertility treatment entails numerous small steps for the patient (initial checks, screens, tests, examinations) throughout the process. This again leads to an organisational understanding of infertility as a partial experience, always separable and testable: it excludes the environment where infertility is experienced.

## **6.2 The emotional body**

This discourse entails, first, the construction of the distressed body, which turns on an interpretation of infertility as an experience defined by grief or a problem to be solved at all costs. This construction opens further possibilities for the justification of medical intervention, and also encompasses the need to fix bodily dysfunctions through non-medical approaches like astrology, vitamin supplements, nutritional advice, and so on, as represented by numerous small businesses exhibiting at the Show. Importantly, this construction positions infertility as more than medical, as if the prospective patient was in distress just by being there. The distressed body is underscored by its opposite, the discursive construction of the successful body. Here, success centres on either achieving pregnancy or a live birth.

### 6.2.1 The distressed body

The discourse (re)constructed around emotions and infertility suggests that being childless causes profound emotional distress. The prospective patient's emotional suffering is discursively constructed by all the analysed organisations attending the Fertility Show. Examples include:

“What can Counselling help you with? *Relationship difficulties; anxiety, stress and depression; feelings of loss and grief; low self-esteem; lack of confidence*”  
(Professional association leaflet).

“No-one should face *the heartache* of struggling to conceive alone and we are with you every step of the way” (NGO newsletter).

Here, the form used is active and the prospective patient is often the agent, and explicitly so – unlike in most of the other discursive constructions we identify. This body is always present in the active voice, with the patient being the main participant, followed by some type of treatment. Nominalisations are absent, because the cause of distress – the relationship difficulties, anxiety, stress, depression, loss, grief, low self-esteem, lack of confidence and heartache - is not placed directly in relation to serial procedures that can be nominalised into one single step, as in the animal and examined bodies. Instead it is placed within a social condition - childlessness. Other key words here are: emotions, rollercoaster, frustrated, confusing, intimidating, feelings, help, support, emotionally draining, failing. Adjectives and nouns are also used more often within this construction than within either construction in the medical body. Their use (re)presents a body that is in a negative emotional condition before, during, and sometimes after treatment (particularly when unsuccessful).

In these texts the prospective patient is hailed less as *thinking*: instead, they are adjured to *feel*. Further, the distressed body directly addresses the prospective patient through the use of the pronoun 'you': this brings the person and their experience of infertility into the discourse, again in contrast to the animal and examined bodies where context and personal pronouns are absent. Here there is a component of attachment to the prospective patient's situation, and treatment is viewed as a way to relieve them of their distress. This differs from the medical body, where detachment from treatment is needed because it is a part of the patient's body, not their emotional experience of infertility, that is not working as it should. The message sent is clear: you cannot be childless and happy. The state of emotional distress can only end once pregnancy and, ideally, a live birth have been achieved.

### **6.2.2 The successful body**

Discursive constructions of success centre on either achieving pregnancy or a live birth. They are closely linked to and connect to the construction of distress as their Other. Examples include:

"Dreams can come true" (Fertility magazine).

"Many couples are *extremely grateful* to her" (Astrology business leaflet).

"... patients in the UK who require IVF in order *to complete their families*" (NGO leaflet).

Examples of words used to (re)construct success and therefore happiness are: dreams, pregnant, to become, outcome, chance, to come true, complete and grateful. The agent is the patient striving to have a baby. A successful body is constructed in the active voice, and the participants are prospective, current, or former patients. There are no hidden agents, and no nominalisations. Significantly, a body hailed as successful only when able to give birth to biological offspring is a body that will not be as successful if it has children through adoption or fostering.

Similar to the distressed body, the use of nouns and pronouns personalises the successful body and brings attention to the context of infertility. This body is constructed in relation to its potential: it is not successful yet, but it will be once treatment leads to pregnancy or a live birth. The words '*your chances of success*' appear often in the analysed texts, and the message sent is that these chances depend in large part on interventions from organisations in the field. Yet the discursive construction of the successful body also sends a message to the prospective patient: you are not successful now, but you might have a chance to be in the future, thanks to us.

To reiterate, success and happiness in this discursive construction are closely linked, and form the Other to the construction of emotional distress. The successful body underscores that happiness is only possible if one has a family - that is, through successful treatment and having a healthy child. Any other outcome would lead to continued emotional distress. As such, a non-reproductive body is constructed as distressed, a reproductive body as successful.

Nevertheless, however low the aforementioned chances may be – the overall birth rate per embryo transferred via IVF in the UK was 23% in 2018 (HFEA, 2018) - they do not depend on the organisations exclusively. Other discursive constructions emerge in these texts: a body that needs to be taken care of by these organisations (passive body), the body that takes care of itself (self-caring body), and the body that is in control of its chances of success (in control body).

### **6.3 The cared for and caring body**

In the first construction in this discourse, the passive body, organisations look after the prospective patient, positioning themselves as active and the patient as needing to be taken care of. The second – the self-caring body - suggests the non-reproductive female body needs to be proactive with regards to certain procedures before, during, or after treatment to achieve a successful outcome. Third, an in control body has control over some of the process of fertility treatment. Being in control is understood here as a form of care because it is (re)constructed as something that will help toward successful treatment: powerlessness is a feeling that only maintains the body in the distressed state associated with childlessness.

#### **6.3.1 The passive body**

In this discursive construction, care is something the prospective patient will be given by the organisation. It takes five different forms: empathising, patronising, supporting, teaching, and treating.

*Empathising.* An exemplar here is “we know what it *feels like*” (private clinic booklet), to denote that the organisation understands the difficulties the female body faces when

opting for fertility treatment: caring for means having the empathy to provide everything this body may need.

*Patronising.* Excerpts like “Walking. It’s free – and good for you!” or “Laughter really is the best medicine!” (both from a fertility magazine) not only recommend activities that might improve fertility, but also imply that the infertile body cannot fully take care of itself, or doesn’t know what will benefit it. Organisations patronise prospective patients by suggesting, clarifying or stressing information, activities and actions that these patients - indeed most people - would understand without any further explanation.

*Supporting.* We can see this in examples like “*let us take you there, we know the way*” (private clinic booklet). Supporting often emerges with regards to counselling, which clinics are required by governmental guidelines to provide.

*Teaching.* This is reflected in data like “It is of vital importance that patients are *well educated* about the disease area and *are kept up to date* on new developments” (NGO newsletter). Here taking care of the body means teaching it about fertility, infertility, reproduction, treatment, tests, and biology. Prospective patients are educated about their bodies and what medical clinics can provide them with in order to successfully deliver a healthy baby.

*Treating.* One nutrition business, advertising in a fertility magazine, tells consumers they are “very sure that *with our tried and tested deep cleanse programme* we would be able *to help*”. As such, treatment here is a way of caring for the patient. It is often described as helping the patient fulfil a dream.



Overall within the construction of the passive body, key words used include help, monitor, clinic, ensure, support, and using the form 'you may want to' in relation to the choices the body has. This grammatical form falls within care as teaching and supporting, but it could also be interpreted as patronising. The use of the word 'we' by all organisations to refer to themselves as being present throughout the female body's fertility journey is also notable. The cared for body is (re)constructed as a passive body requiring organisational care in order to achieve a better state in relation to fertility, or a live birth. It is not primarily a body with agency: rather, similarly to the successful body, this female body needs to reach out to the relevant organisations in order to later be cared for by them and hence get closer to being successful.

### **6.3.2 Self-caring body**

This discursive construction suggests the non-reproductive female body needs to be proactive with regards to certain procedures before, during, or after treatment. Phrases like "do your homework" aimed at attendees by counsellors or doctors at the Show imply that, as non-reproductive bodies, they are required to take steps for their own benefit and these steps cannot be taken by anyone else. Whereas care is *offered to* the body, self-care is *expected from* the body. Examples include:

"Whether your semen analysis results are good or bad *you can potentially improve your chances of success* by having a healthy diet and lifestyle" (professional association leaflet).

"Women who are trying to become pregnant should be informed that *drinking no more than 1 or 2 units of alcohol once or twice per week and avoiding episodes of*

*intoxication reduces the risk of harming a developing f[et]us*" (National Institute for Health and Care Excellence Guidelines).

Similar to the constructions of the distressed body and the successful body, the self-caring body brings the prospective patient to the fore by explicitly addressing them through the use of 'you' and 'your'. They are enjoined to work on their diet, lifestyle and alcohol intake. This construction is widely present within the selected texts. Examples of key words used to construct self-care are: changes, should be informed, keep in check, you may want to, to make sure, you will, you must, you should, you can, and imperative forms like 'stop smoking', 'keep cool', 'drink sensibly', or 'think about'. The form is either imperative (ordering or requesting an action) or active, and the agent is the prospective patient. Other participants include the clinic, healthcare professionals and conditions, drugs, and tests related to fertility. No nominalisations were found in relation to this discursive construction. Rather, the self-caring body is constructed by all organisations through the use of the imperative and modal verbs like *should*. Hence, the emphasis is not on a set of procedures (as with previously noted nominalisations) but on actions and practices that the consumer should take into consideration in order to increase their chances of conception.

This subject position therefore hails the consumer as wanting to take care of themselves, but also suggests they might not know how to do this. Self-care is expected, but requires a level of organisational care too: you should follow a healthy lifestyle (self-care), but might not know where to begin (cared for); you should talk to your clinician (self-care), but might not know which questions to ask (cared for).

### 6.3.3 The in control body

This discursive construction refers to prospective patients having control over some of the process of fertility treatment. For example, clinics state that they “will do whatever it takes to live up to your expectations” (private clinic booklet), or make sure patients know they can always change their minds about, for instance, storing their frozen eggs or sperm. Other examples include:

“[Our] accredited counsellors...are trained to help you talk about how you are feeling, and to help you *make choices in your life* to be able to *cope better* with things that seem beyond your control” (Professional association leaflet).

“Patients should have the opportunity to *make informed decisions* about their care and treatment, in partnership with their healthcare professionals” (NICE Guidelines).

Examples of key words used to construct the in control body are: choices, to enable, to cope with, ready, consented, informed decisions and changes. The form is active and the agent is usually the text consumer. There are no nominalisations in relation to this discursive construction. The in control body is mostly constructed through the use of imperatives rather than specific words.

This body is a (re)construction that employs nouns and pronouns substantially to directly address the prospective patient. Here, then, the responsibility for achieving a successful live birth is shifted toward the text consumer. This is not necessarily negative: the organisation is telling the prospective patient that their situation is not out of their control, that there are steps that they can take in order to make the outcome

potentially positive. However, the in control body differs from the self-caring body. In the former, the prospective patient is required to be proactive in relation to their chances of attaining pregnancy and a live birth. However, self-care relates to a dimension of responsibility or lack of thereof (if you don't take care of yourself, your chances of success will not increase), whereas being in control relates to a more tangible possibility (you can do this, you are at the steering wheel) and a more positive form of responsibility. This has a double effect. On the one hand this subject position provides a level of certainty about possible outcomes; but it also removes responsibility from the organisation, in that when the one in control is the prospective patient, any outcome will be the result of their (lack of) self-care and/or ability to be in control. Being in control is constructed as happening in parallel with being taken care of and taking care of oneself: both the organisations taking care of the body and the body taking care of itself are contributing to the creation of a sense of control over the patient's reproductive future, however uncertain it may be.

Overall, the discourse of the cared for and caring body relates to responsibility: the cared for body has little responsibility and is mainly a passive recipient of organisational practices; the self-caring body has significant responsibility and accountability for failure (if you didn't get pregnant then you didn't try hard enough/ your lifestyle is inadequate, etc.); whereas the in control body is given, by the organisations constructing it, a sense of control over both the process and the outcome of treatment, thus reducing possible feelings of powerlessness. In the case of private clinics, this last (re)construction of the body might also work to retain the prospective patient as a returning customer: if the treatment did not work the first time(s), it was because they were not controlling the process well enough.

Here differences emerge between the component discursive constructions (passive, self-caring, and in control) which primarily have to do with agency. In the first, no agency is required: the prospective patient only has to be taken care of - indeed, it seems like they *cannot do anything but be taken care of*. But the discursive constructions of self-care and in control require patients to be proactive, and encourage the exercise of agency. Discourses of health, stress management, and even the management of one's romantic and sexual life are brought into focus by organisations and (re)constructed as practices of care and self-monitoring practices requiring agency. Nonetheless, for us these are perhaps less at variance with the other discourses than they seem in that agency appears here as simultaneously given and managed by organisations, rather than emerging from the female body itself.

## **7. EMOTIONAL ROLLERCOASTERS, THE JOY OF MOTHERHOOD, AND THE PERSONIFICATION OF POTENTIAL FUTURE LIFE**

While we have separated the three discourses and the subject positions they construct for analytical purposes, they co-exist and interrelate throughout the materials we analysed. In these interrelations, the infertile subject is hailed as a mother-to-be who is on an emotional rollercoaster to fulfil 'the dream' of biologically reproducing.

The notion of fertility treatment as emotional rollercoaster emerges when we consider how the medical body and emotional body discourses interrelate. This normalises the emotional body and fortifies the dichotomy of distress and success. In the relevant texts, prospective patients are often reminded that the rollercoaster is a normal price to pay in order to remove suffering, through interventions into parts of the medical body, and to be successful:

“The staff...gave me all the time and individual care I needed during *my roller coaster journey to parenthood*” (former patient quoted in private clinic booklet)

“*A beginners’ guide to the fertility rollercoaster – what to expect.* If you are about to start fertility treatment for the first time, you may have heard that emotionally and physically, *you are in for a bumpy time.*”

(Fertility Show guidebook, 2013)

The metaphor of a rollercoaster is of course the epitome of passivity: all the subject being hailed here can do is strap in for the ride ahead, which is going to be a very difficult one. The interventions into her medical body that she will endure will be done to her, not by her. Such normalisation is also strongly suggestive of the emotional lows related to fertility treatment being worthwhile in light of the potential future life that will ‘complete the family’ and relieve the distressed body from its suffering. This message is amplified in the attribution of human qualities to the embryo and/or the egg, discursive elements of the medical body, as shown in the following excerpt from Author A’s field notes:

2/11/2014. Seminar on the basics on infertility. The medical director of a fertility clinic shows us a picture of “a *beautiful* human egg” and tells us that in IVF, they look for signs of fertilisation. He shows pictures of fertilised eggs on day 1, day 2, 3, 4, 5... “This is a picture of a *beautiful* embryo”, then, on day 5, “this is a picture of a *beautiful* blastocyst”.

In an organisational environment that exalts the embryo, women who are unlikely to achieve pregnancy and witness such beauty are told that

“age is *unkind* to women... women have different ages of menopause...we do not have any test to predict menopause” (medical director of fertility clinic, fieldnotes 2/11/2014)

This however is not explicitly used to hail the infertile subject as in distress. Instead,

“Women *are special* and are born with a certain number of eggs”, while men produce sperm every 30 min[utes] or so” (medical director of fertility clinic 2, fieldnotes 3/11/2013)

What makes women ‘special’ (their biological attributes, an element of the medical discourse) is also what removes their agency: the diminishing number of eggs with age (another element of the same discourse) makes a fertilised embryo something to be cherished because of its ability to potentially generate life.

Indeed the personification of future life emerges alongside the emotional rollercoaster trope as a discursive tool reinforcing organisational pressure towards treatment until a successful outcome is achieved. Again this can be seen in the interrelations between the discourses of the medical body and the emotional body. Of course this tool is nothing new at the societal level: scholars have highlighted how the UK anti-choice movement already personifies the foetus in their campaigns against abortion (Lowe, 2016; 2019). However, in the context of fertility treatment this personification begins even earlier, well before the embryo becomes a foetus. For example, on the first page

of its booklet, one fertility clinic uses a picture of a blastocyst with the caption “*This is Ben, when he was five days old*”.

Another key interrelation, this time between constituent subject positions in the emotional body discourse, (re)constructs the ‘joy of motherhood’. This emerges in the texts as a very painful absence that hails a distressed body, while simultaneously fuelling conceptions of what a successful body should feel and look like. For example:

“...when a woman who *desperately wants a baby* of her own is suddenly *surrounded by pregnant friends* it can even become ‘*disruptive*’ for her *emotional balance* and can, in turn, have an effect on her relationships with her partner and wider family. The situation... quite simply leaves the woman feeling out of control. The *disappointment and impatience* are such that very strong emotions can result: *anger, sadness, frustration, negativity and powerlessness*” (fertility magazine article).

“*No-one understands the pain of infertility until it happens to you*, the guilt of not being able to reproduce as a ‘normal’ woman, not being able to give my husband a son or daughter, nor give our parents a grandchild; *the feeling of failure every time you see a happy family* having fun on a sunny Sunday afternoon. What could help, you ask? The doctors have offered me anti-depressants – *will they make me a mum – NO – so why just mask the problem if it isn’t going to take it away* [?]” (Letter from a volunteer, NGO magazine).

In these excerpts, we can see how, within the discourse of the emotional body, constructions of the distressed and successful body not only coexist but are interdependent: the woman who ‘desperately wants a baby’ (distressed body) finds



her emotional balance compromised when she 'is suddenly surrounded by pregnant friends' (successful body). The 'feeling of failure' (distressed body) experienced by the NGO volunteer arises whenever she sees 'a happy family' (successful body); her body is so distressed that, even when attempts are made to remove the distress (here through anti-depressants), success is not achieved because she is not going to become a mother.

The three discourses, their constituent subject positions and their interrelations therefore all hail the infertile subject as a (prospective and potentially returning) customer within this organisational field, sitting in the governmentality continuum of self-management and organisational management of their health, sex life and reproductive choices. Lemke (2001, p. 191) points to two facets of governmentality – representation and intervention. Representation allows the definition of “a discursive field in which exercising power is ‘rationalised’. This occurs...by the delineation of concepts, the specification of objects and borders, the provision of arguments and justifications, etc.”. Representation also “enables a problem to be addressed and offers certain strategies for solving/handling the problem”. Intervention provides “political technologies” that can address the issues at stake. Such technologies “include agencies, procedures, institutions, legal forms...that are intended to enable us to govern the objects and subjects of a political rationality” (Lemke, 2001, p. 191).

In terms of representation, we see infertility presented in our texts as a medical problem for cis women which needs to be resolved via a healthy pregnancy and a live birth because it creates emotional distress. As to intervention, medical technologies are held up as one important solution, including semen assessment, vitrification,

insemination and embryo transfer. These interventions into parts of the body, and the female body especially, are always carried out by invisible medical experts to fix physical malfunctions, parts of the body that do not work. Our fertility organisations also promise to intervene in infertility by offering non-medical treatments like vitamin supplements or astrology, or by caring for non-reproductive bodies whilst simultaneously constructing specific sorts of agency that they should take up in order to maximise the chances of success. The organisational discourses of the non-reproductive female body as medical, emotional and cared for and caring therefore bring together the representation and intervention sides of governmentality by illuminating how particular subject positions are made available by organisations within fertility treatment. These positions, as intersecting instances of biopower, point to a convergence between government of the self and government by the self, and are permeated by power relations (Foucault & Blasius, 1993).

In fact the interrelations of discourses and subject positions presented here might obscure this governmentality, as they hail an infertile subject that is in constant need of organisational intervention at all stages of treatment (before, during, and afterwards) due to them being constructed, by default, as an emotional mother-to-be, willing to relinquish (at least some) agency in order to experience the joy of motherhood.

## **8. CONCLUSION**

This paper contributes to debates on the interrelations between organisations and reproductive life stages by showing how the non-reproductive female body is (re)constructed by organisations involved in the fertility industry. It intervenes in these debates, first, by foregrounding the infertile body, which is currently absent from OS

research. Second, we reposition the analysis away from the employment relationship and how women are often expected to discipline their (post-)reproductive bodies, attending instead to how organisations in the field of fertility treatment (re)present and therefore hail non-reproductive female bodies. We should reiterate that transgender and gender non-conforming people's bodies are entirely absent from these (re)presentations – bodies here are wholly cis. Further, the discourses emerging from our analysis are not isolated from each other, but instead give rise to specific subject positions pointing to a body that, when infertile, is medically malfunctioning, emotionally suffering, and cared for and caring.

Significantly, through these discourses the non-reproductive body finds itself in the governmentality continuum that requires individuals to be at once objects and subjects of power within an entire organisational field. The distribution of discourses is dispersed and spread across different types of organisations – the government, private clinics, NGOs, NHS Foundation Trusts, professional associations and other businesses providing advice on things like nutrition and vitamin supplements.

At the heart of what Phelan (1990, p.429) calls “the Foucauldian challenge” is the ability to “trace the effects of power, both as something used upon us and something we participate in”. The questions of existing versus potential life and of agency are part of this challenge, and are intimately linked with reproductive justice, indexed in section 3. The current waves of hostility in this space remind us that a right, once obtained, cannot be taken for granted; and how, once it has been fought for and obtained, efforts must continue for us to exercise it safely – against, say, the recent wave of (attempted) abortion bans in the US and the picketing of UK abortion clinics.

Reproductive rights are part of these efforts and, when considered in the context of production and reproduction, of market, workplace and wider society, we should continue to question whether social expectations of motherhood and organisational expectations of (re)production can organically co-exist. Can a cis woman remain childless – medically, socially and/ or electively - without being subject to such pressures? Can she remain childless and be happy? Being seen as flawed, suffering and passive when not-mother or a mother-to-be signifies a long road ahead to detach the productive from the reproductive, and the reproductive from the human, the self-standing, and the worthy – from Butler’s (1993) bodies that matter.

With regards to OS discussions of reproduction, our analysis underscores these dichotomous expectations of the female body. As a potential carrier of future life, this body will have to respond to these obligations regardless of whether it houses a successful pregnancy. We thus expand the arguments in such discussions around the mismatch between social obligations - adhering to norms around maternal health - and organisational obligations - maintaining professionalism at work. When we account for the non-reproductive female body, should it reproduce following fertility treatment, social expectations of motherhood would be fulfilled, but the woman’s productivity would likely be questioned. On the other hand, should the treatment fail, organisational expectations would likely be met, but social obligations around motherhood would remain unfulfilled. The time and likely expense necessitated by fertility treatment may well also conflict with organisational obligations. This fuels problematic ambiguities with regards to fertility treatment and women’s reproductive ‘choice’, which deserve further investigation.

Not unrelatedly, our analysis also offers opportunities to widen the current debate around reproduction, women's bodies, and agency vis-à-vis a potential future life. Significantly, it suggests that discourses on the personification of such life are not only (re)constructed through anti-choice organisations acting at the civil society level. They also happen within the market, through organisations that explicitly exist in order to render the infertile body fertile, and can arguably be seen as a pillar of reproductive choice in some parts of the world. Thus, and uneasily, we see the (re)construction and concomitant hailing of women's bodies as the vessels for future life in both arenas. The medical discourse renders women's bodies as mere collections of biological parts to be scrutinised, which arguably compounds this, undercutting the subject positions generated by long-established feminist discourses around reproductive autonomy (see, for example, Longhurst, 1999; Martin, 1989; Pollitt, 1998; Raphael-Leff, 1991; Roberts, 1998).

We can thus see fertility treatment organisations hailing the infertile subject by managing their agency (within the discourses of the medical and cared for and caring body, as well as the personification of potential future life); by constructing it as an emotional mother-to-be by default (within the discourse of the emotional body, and the interrelation of the joy of motherhood); and by normalising distress as something to expect pre-, during, and post-fertility treatment (within the discourse of the emotional body, and the metaphor of treatment as emotional rollercoaster).

There is ample room for other research in this space moving forward, including explorations of how cis male bodies are (re)constructed in organisational discourses and practices around infertility and fertility treatment and how trans men's and gender

non-conforming people's bodies experience fertility and/or infertility. Our analysis also offers a different angle on the delineation of processes of subjectification in relation to our reproductive lives by bringing fertility treatment organisations into the picture. The discourses we present are by no means all-powerful, so we need to understand how those being hailed by the relevant texts respond. What we chronicle here could therefore be regarded as the 'opportunity costs' of the subject positions we identify, providing critical food for thought about how the hailing they entail may, in turn, be resisted. After all, as Foucault (1978, p.143) himself suggests, "It is not that life has been totally integrated into techniques that govern and administer it; it constantly escapes them".

## REFERENCES

Association of Lawyers for the Defence of the Unborn (1984). *Secretary Report on Activities of the Association, Winter 1984 Newsletter*. Retrieved from <https://aldunewsletters.blogspot.it> on 8<sup>th</sup> December 2020.

Atkinson, C., Beck, V., Brewis, J., Davies, A. & Duberley, J. (2020). Menopause and the Workplace: New Directions in HRM Research and HR Practice. *Human Resource Management Journal*, Early View. doi: [10.1111/1748-8583.12294](https://doi.org/10.1111/1748-8583.12294).

BBC News (2019, October 29). Alabama Abortion Law: Judge Blocks Bill From Taking Effect. Retrieved from <https://www.bbc.co.uk/news/world-us-canada-50223637>.

BBC News (2021, May 20) Abortion: Texas Governor Signs Restrictive New Law. Retrieved from <https://www.bbc.co.uk/news/world-us-canada-57177224>.

Becker, L. C. & Becker, C. B. (1992). *Encyclopedia of Ethics*. New York: Garland.

- Boncori, I. & Smith, C. (2019). I Lost My Baby Today: Embodied Writing and Learning in Organizations. *Management Learning*, 50(1), 74-86. doi: [10.1177/1350507618784555](https://doi.org/10.1177/1350507618784555)
- Brunner, L. K. & Dever, M. (2014). Work, Bodies and Boundaries: Talking Sexual Harassment in the New Economy. *Gender, Work & Organization*, 21(5), 459-471. doi: [10.1111/gwao.12048](https://doi.org/10.1111/gwao.12048)
- Burr, V. (2003). *Social Constructionism*. 2nd Ed. London: Routledge.
- Butler, J. (1993). *Bodies That Matter: On the Discursive Limits of "Sex"*. New York: Routledge.
- Cohen, D. (1993). Private Lives in Public Spaces: Marie Stopes, the Mothers' Clinics and the Practice of Contraception. *History Workshop*, 35, 95–116.
- Connolly, M-L. (2019, 22 October). Northern Ireland Abortion Law Changes: What Do They Mean? *BBC News*. Retrieved from <https://www.bbc.co.uk/news/uk-northern-ireland-50125124>.
- Corea, G. (1986). The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs. *MCN: The American Journal of Maternal/Child Nursing*, 11(5), 357-363.
- Deleuze, G. (1986). *Foucault*. Minneapolis: University of Minnesota Press.
- Department of Health and Social Security (1984). *Report of the Committee of Inquiry into Human Fertilisation and Embryology*. Retrieved from <https://www.hfea.gov.uk/media/2608/warnock-report-of-the-committee-of-inquiry-into-human-fertilisation-and-embryology-1984.pdf>
- Elder, K. & Johnson, M. H. (2015a). The Oldham Notebooks: An Analysis of the Development of IVF 1969-1978. I. Introduction, Materials and Methods. *Reproductive BioMedicine Online*, 1, 3-8. doi: [10.1016/j.rbms.2015.04.001](https://doi.org/10.1016/j.rbms.2015.04.001)

- Elder, K. & Johnson, M. H. (2015b). The Oldham Notebooks: An Analysis of the Development of IVF 1969-1978. II. The Treatment Cycles and Their Outcomes. *Reproductive BioMedicine Online*, 1, 9-18. doi: [10.1016/j.rbms.2015.04.003](https://doi.org/10.1016/j.rbms.2015.04.003)
- Elder, K. & Johnson, M. H. (2015c). The Oldham Notebooks: An Analysis of the Development of IVF 1969-1978. III. Variations in Procedures. *Reproductive BioMedicine Online*, 1, 19-33. doi: [10.1016/j.rbms.2015.04.004](https://doi.org/10.1016/j.rbms.2015.04.004)
- European Data Journalism Network (2019). *Even Where Abortion is Legal, Access is Not Granted*. Retrieved from <https://www.europeandatajournalism.eu/eng/News/Data-news/Even-where-abortion-is-legal-access-is-not-granted>
- Fairclough, N. (1989). *Language and Power*. 2nd Ed. Harlow: Longman.
- Fairclough, N. (1992). *Discourse and Social Change*. Cambridge: Polity Press
- Fairclough, N. (1995a). *Critical Discourse Analysis: The Critical Study of Language*. London: Longman.
- Fairclough, N. (1995b). *Media Discourse*. London: Hodder Education.
- Fairclough, N. & Wodak, R. (1997). Critical Discourse Analysis. In Van Dijk, T. A. (ed) *Discourse as Social Interaction. Discourse Studies: A Multidisciplinary Introduction, Volume 2*. London: Sage.
- Firestone, S. (1970). *The Dialectic of Sex. The Case for Feminist Revolution*. New York: Bantam.
- Fleming, A. (2018, 20 June). Would You Give Up Having Children to Save the Planet? Meet the Couples Who Have. *The Guardian*. Retrieved from <https://www.theguardian.com/world/2018/jun/20/give-up-having-children-couples-save-planet-climate-crisis>.
- Foucault, M. (1972). *The Archaeology of Knowledge*. London: Routledge.



Foucault, M. (1978). *The History of Sexuality. Volume 1: An Introduction*. New York: Vintage Books.

Foucault, M. (1980). *Power/Knowledge. Selected Interviews and Other Writings by Michel Foucault, 1972-1977*. Edited by Gordon, C. New York: Pantheon Books.

Foucault, M., & Blasius, M. (1993). About the Beginning of the Hermeneutics of the Self: Two Lectures at Dartmouth. *Political Theory*, 21(2), 198-227. doi: [10.1177/0090591793021002004](https://doi.org/10.1177/0090591793021002004)

Fox, A. B. & Quinn, D. M. (2015). Pregnant Women at Work: The Role of Stigma in Predicting Women's Intended Exit from the Workforce. *Psychology of Women Quarterly*, 39(2), 226-242. doi: [10.1177/0361684314552653](https://doi.org/10.1177/0361684314552653)

Gallagher, C. & Laqueur, T. (eds) (1987). *The Making of the Modern Body. Sexuality and Society in the Nineteenth Century*. Berkeley: University of California Press.

Gatrell, C. (2013). Maternal Body Work: How Women Managers and Professionals Negotiate Pregnancy and New Motherhood at Work. *Human Relations*, 66(5), pp. 621–644. doi: [10.1177/0018726712467380](https://doi.org/10.1177/0018726712467380)

Gatrell, C., Cooper, C.L. & Kossek, E.E. (2017). Maternal Bodies as Taboo at Work: New Perspectives on the Marginalizing of Senior-Level Women in Organizations. *Academy of Management Perspectives*, 31(3), pp. 239–252. doi: [10.5465/amp.2014.0034](https://doi.org/10.5465/amp.2014.0034)

Gioia, D., Corley, K., & Hamilton, A. (2012). Seeking Qualitative Rigor in Inductive Research: Notes on the Gioia Methodology. *Organizational Research Methods*, 16 (1), 15-31. doi: [10.1177/1094428112452151](https://doi.org/10.1177/1094428112452151)

Gordon, I. (1996). *Controlled Reproduction in Cattle and Buffaloes*. Oxford: CAB International.

- Grandey, A.A., Gabriel, A.S., & King, E. (2020). Tackling taboo topics: A review of the three Ms in working women's lives. *Journal of Management*, 46(1), 7-35. doi: [10.1177/0149206319857144](https://doi.org/10.1177/0149206319857144)
- Harding, N. (2002). On the Manager's Body as an Aesthetics of Control, *Tamara: Journal of Critical Postmodern Organization Science*, 2(1), 63–76.
- Harding, S. (1991). *Whose Science? Whose Knowledge? Thinking from Women's Lives*. Ithaca, NY: Cornell University Press.
- Hassard, J., Holliday, R., & Willmott, H. (2000). Introduction: The Body & Organization. In: Hassard, J., Holliday, R. & Willmott, H. (eds.), *Body and Organization*. London: Sage.
- Hockey, J., & Allen-Collinson, J. (2009). The Sensorium at Work: The Sensory Phenomenology of the Working Body. *Sociological Review*, 17(2), 217–239. doi: [10.1111/j.1467-954X.2009.01827.x](https://doi.org/10.1111/j.1467-954X.2009.01827.x)
- Hope, A. (2011). The Body: A Review and a Theoretical Perspective. In Jeanes, E., Knights, D. and Martin, P.Y. (eds.) *Handbook of Gender, Work & Organization*. Chichester: Wiley.
- Human Fertilisation and Embryology Authority (2018). *Fertility Treatment 2018: Trends and Figures*. Retrieved from <https://www.hfea.gov.uk/about-us/publications/research-and-data/fertility-treatment-2018-trends-and-figures/> on 15<sup>th</sup> December 2020.
- Hunt, E. (2018, 12 March). BirthStrikers: Meet the Women Who Refuse to Have Children Until Climate Change Ends. *The Guardian*. Retrieved from <https://www.theguardian.com/lifeandstyle/2019/mar/12/birthstrikers-meet-the-women-who-refuse-to-have-children-until-climate-change-ends>.

- Hunter, C., & Kivinen, N. (2016). Constructing Girlhood: Abject labour in Magazine Offices. *Gender, Work and Organization*, 23(6): 551-565.
- Huopainen, A. & Satama, S. (2019). Writing Birthing Bodies: Exploring the Entanglements Between Flesh and Materiality in Childbirth. *Culture and Organization*, Online First. doi: [10.1080/14759551.2019.1618854](https://doi.org/10.1080/14759551.2019.1618854)
- Iglesias, T. (1984, 22 September). Test-Tube Ethics. *The Tablet*. Retrieved from <http://archive.thetablet.co.uk/>.
- Jack, G., Riach, K. & Bariola, E. (2018). Temporality and Gendered Agency: Menopausal Subjectivities in Women's Work. *Human Relations*, 72(1), 122-143. doi: [10.1177/0018726718767739](https://doi.org/10.1177/0018726718767739)
- Johnson, M. H., & Elder, K. (2015). The Oldham Notebooks: An Analysis of the Development of IVF 1969-1978. IV. Ethical Aspects. *Reproductive BioMedicine Online*, 1(1), 34-45. doi: [10.1016/j.rbms.2015.04.002](https://doi.org/10.1016/j.rbms.2015.04.002)
- Klasing, A. (2018) US Blocks Funds to UN Population Fund – Again. *Human Rights Watch*. Retrieved from <https://www.hrw.org/news/2018/03/16/us-blocks-funds-un-population-fund-again>
- Lalli, C. (2016, 26 February). L'Aborto è un Servizio Medico ma è Trattato come un Problema Morale. [Abortion is a Medical Service But It is Treated as a Moral Problem]. *Internazionale*. Retrieved from <http://www.internazionale.it/opinione/chiara-lalli/2016/02/26/aborto-servizio-medico>
- Lemke, T. (2001). 'The birth of bio-politics': Michel Foucault's lecture at the College de France on neo-liberal governmentality. *Economy and Society*, 30(2), 190-207. doi: [10.1080/03085140120042271](https://doi.org/10.1080/03085140120042271)
- Longhurst, R. (1999). Pregnant Bodies, Public Scrutiny: "Giving" Advice to Pregnant Women. In Teather, E.K. (ed.) *Embodied Geographies*, London: Routledge.

Lowe, P. (2016). *Reproductive Health and Maternal Sacrifice: Women, Choice and Responsibility*. Palgrave Macmillan.

Lowe, P. (2019). (Re)imagining the 'Backstreet': Anti-Abortion Campaigning Against Decriminalisation in the UK. *Sociological Research Online*, 24(2), 203-218. doi: [10.1177/1360780418811973](https://doi.org/10.1177/1360780418811973)

Lowe, P. & Hayes, G. A. (2019). Anti-Abortion Clinic Activism, Civil Inattention, and the Problem of Gendered Harassment. *Sociology*, 53(2), 330-346. doi: [10.1177/0038038518762075](https://doi.org/10.1177/0038038518762075)

Martin, E. (1989). *The Woman in the Body: A Cultural Analysis of Reproduction*.

Milton Keynes: The Open University Press

Martin, E. (1990). Science and Women's Bodies: Forms of Anthropological Knowledge. In Jacobus, M., Fox Keller, E. and Shuttleworth, S. (eds.) *Body/Politics*. New York: Routledge.

McDonald, H., Graham-Harrison, E. & Baker, S. (2018, 26 May). Ireland Votes by Landslide to Legalise Abortion. *The Guardian*. Retrieved from <https://www.theguardian.com/world/2018/may/26/ireland-votes-by-landslide-to-legalise-abortion>.

Oakley, A. (1984). *The Captured Womb*. New York: Blackwell.

Pfeffer, N. (1987). Artificial Insemination, In-Vitro Fertilization and the Stigma of Infertility. In Stanworth, M. (ed.) *Reproductive Technologies. Gender, Motherhood and Medicine*. Cambridge: Polity Press.

Pfeffer, N. (1993). *The Stork and the Syringe. A Political History of Reproductive Medicine*. Cambridge: Polity Press.

Phelan, S. (1990) Foucault and Feminism. *American Journal of Political Science*, 34(2), 421-440. doi: [10.2307/2111456](https://doi.org/10.2307/2111456)

Pollitt, K. (1998). "Fetal Rights": A New Assault on Feminism. In Weitz, R. (ed.), *The Politics of Women's Bodies: Sexuality, Appearance and Behavior*. New York: Oxford University Press.

Porschitz, E.T. & Siler, E.A. (2017) Miscarriage in the Workplace: An Autoethnography. *Gender, Work & Organization*, 24(6), 565-578. doi: [10.1111/gwao.12181](https://doi.org/10.1111/gwao.12181)

Raphael-Leff, J. (1991). *Psychological Processes of Childbearing*. London: Chapman and Hall.

Rich, A. (1976). *Of Woman Born: Motherhood as Experience and Institution*. New York: Norton.

Roberts, D. E. (1998). The Future of Reproductive Choice for Poor Women and Women of Color. In Weitz, R. (ed.) *The Politics of Women's Bodies: Sexuality, Appearance and Behavior*. New York: Oxford University Press.

Rowland, R. (1985). A Child at Any Price?: An Overview of Issues in the Use of the New Reproductive Technologies, and the Threat to Women. *Women's Studies International Forum*, 8(6), 539-546. doi: [10.1016/0277-5395\(85\)90091-3](https://doi.org/10.1016/0277-5395(85)90091-3)

Sayers, J.G. & Jones, D. (2015). Truth Scribbled in Blood: Women's Work, Menstruation and Poetry. *Gender, Work & Organization*, 22(2), 94-111. doi: [10.1111/gwao.12059](https://doi.org/10.1111/gwao.12059)

Soloway, R. A. (1995). The 'Perfect Contraceptive': Eugenics and Birth Control Research in Britain and America in the Interwar Years. *Journal of Contemporary History*, 30(4), 637-664.

Stopes, M. C. (1921). *Married Love: Or, Love in Marriage*. Truth Publishing Company.

Terkel, A. & Bassett, L. (2017, 21 January). Donald Trump Reinstates Ronald Reagan's Abortion Global Gag Rule. *The Huffington Post*. Retrieved from

[http://www.huffingtonpost.com/entry/donald-trump-global-gag-rule\\_us\\_58822355e4b070d8cad1f774](http://www.huffingtonpost.com/entry/donald-trump-global-gag-rule_us_58822355e4b070d8cad1f774)

The Fertility Show (2019). The Fertility Show returns to London's Olympia 1-3 November. Retrieved from <https://www.fertilityshow.co.uk/london>

Trethewey, A. (1999). Disciplined Bodies: Women's Embodied Identities at Work. *Organisation Studies*, 20(3), 423–450. doi: [10.1177%2F0170840699203003](https://doi.org/10.1177/0170840699203003)

Vaara, E., Tienari, J., & Laurila, J. (2006). Pulp and Paper Fiction: On the Discursive Legitimation of Global Industrial Restructuring. *Organization Studies*, 27(6), 789-813. doi: [10.1177%2F0170840606061071](https://doi.org/10.1177/0170840606061071)

Van Amsterdam, N. (2015). Othering the 'Leaky Body': An Autoethnographic Story about Expressing Breast Milk in the Workplace. *Culture and Organization*, 21(3), 269-287. doi: [10.1080/14759551.2014.887081](https://doi.org/10.1080/14759551.2014.887081)

Van Dijk, T. A. (ed.) (1997). *Discourse as Structure and Process. Discourse Studies. A Multidisciplinary Introduction. Volume 1*. London: Sage.

Van Dijk, T.A. (2015). Critical Discourse Analysis. In Tannen, D., Hamilton, H. E., and Schiffrin, D. (eds.) *The Handbook of Discourse Analysis*. Chichester: John Wiley & Sons.

Williams, S. J. (1997). Modern Medicine and the "Uncertain Body": From Corporeality to Hyperreality? *Social Science & Medicine*, 45(7), 1041-1049. doi: [10.1016/S0277-9536\(97\)00031-2](https://doi.org/10.1016/S0277-9536(97)00031-2)

Wodack, R. & Meyer, M. (eds.) (2009). *Methods of Critical Discourse Analysis*. 2nd Ed. London: Sage.

Wolkowitz, C. (2006). *Bodies at Work*. London: Sage.

**Table 1. Emerging discourses, discursive constructions, and elements of grammar**

Discourse	Discursive constructions	Elements of grammar			
		Participants	Agents	Voice	Examples of nominalisations
Medical body	<i>Animal</i>	Body parts.	Hidden or removed.	Passive.	Assisted hatching; fertilisation; vitrification of gametes and embryos; insemination of eggs; assisted conception.
	<i>Examined</i>	Patients, body parts.	Hidden or removed.	Passive.	Fertilisation; intrauterine insemination; blastocyst transfer; uterine cavity assessment.
Emotional body	<i>Distressed</i>	Prospective patient.	Explicit – the prospective patient.	Active.	Absent. The cause of distress is not placed in nominalised procedures, but rather on the state and condition of childlessness.
	<i>Successful</i>	Prospective, current, or past patient.	Explicit – the prospective patient.	Active.	Absent. The cause of distress is not placed in nominalised procedures, but rather on the condition of childlessness.
Cared for and caring body	<i>Passive</i>	Prospective patients, the clinic, and the government.	Explicit - the clinic, the specialist, or the doctors.	Active.	Fertility tracking, fertility check, individualised care, personalised treatment.
	<i>Self-caring</i>	Text consumer, prospective patient.	Explicit – text consumer, prospective patient.	Active.	Absent. This discursive construction emerges through the use of the imperative form and the modal verb 'should'.

	<i>In control</i>	Text consumer, prospective patient.	Explicit – text consumer, prospective patient.	Active.	Absent. This discursive construction emerges through the use of the imperative form.
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