Normalizing Assisted Reproduction  (Review of Making Parents: The Ontological Choreography of Reproductive Technology by Charis Thompson)

With over 120,000 cycles and 35,000 births annually in the United States, assisted reproduction is firmly ensconced within the medical care system. It is avidly sought by persons unable to have children and is an attractive career alternative for obstetrician-gynecologists.

Assisted reproductive technologies (ARTs) teem with ethical and health policy issues. The ethical questions involve the status and control of extracorporeal embryos, the technologization of family and reproduction, and the ability to recombine genetic, gestational, and social parentage. Having garnered enormous public attention, the outcome of ethical debates will play a major role in speeding the assimilation of these techniques and offshoots, like embryonic stem cell harvesting, expected in the future.

Health policy questions have received less attention but are equally important. Intensive scrutiny has not confirmed suspicions about a higher rate of birth defects in ART offspring. Good longitudinal data, however, is missing, so further research and attention is needed. While success rates have grown to 30% per cycle in the best clinics, improving the take-home baby rate for all age and diagnostic groups remains a challenge.

The most pressing health policy problem is the high rate of twinning--roughly a third of IVF births, with a somewhat lower rate in Europe. Although infertile patients often welcome twins, the higher medical and social costs which twins present are largely borne by others. Sweden and Belgium have used insurance incentives to encourage patients to accept single-embryo transfer. A lower twinning rate in the United States depends on altering patient perceptions of the desirability of twins. In the American pay-
as-you-go funding system, few levers exist to dampen patient enthusiasm for two babies at the price of one.

ARTs also raises access questions. Few states mandate insurance coverage and fewer policies provide it, so ARTS are rationed by the ability to pay direct out-of-pocket charges. Although infertility is a source of suffering in all economic groups, most people perceive access to basic health as a more pressing problem. The Clinton health care plan, for example, specifically excluded IVF, and no one now seriously argues that the financially-strapped Medicaid system should cover ARTs.

Making Parents: the Ontological Choreography of Reproductive Technologies is a work of medical ethnography based on the author’s observations in two ART clinics and her later role as a successful ART patient. Health policy rarely looks at problems experientially. Nonetheless good medical ethnography provides insights that enrich a policymaker’s understanding of being a patient or provider and the power of institutional forces shaping their activities.

There are some nodes of insight in Charis Thompson’s heavily jargonized ethnographic framing of a field that others see through patient, provider, or policymaker lenses. While some of her terms are evocative and insightful, others border on the tendentious or parodic. For example, her term “epistemic disciplining” is a useful way to describe what happens to all patients who must submit to the demands of medical and health care systems. As technical experts and gatekeepers, providers control much of the information relevant to medical encounters and parcel it out in ways to manage patients and expedite their work. Patients must struggle to obtain additional knowledge or control
and may be “disciplined” if their efforts interfere too much with institutional routines, giving yet another meaning to the term “managed care.”

Her notion of “agency and objectification” is also useful for reminding us that infertile persons voluntarily choose to have the intimacies of their reproduction reduced to the medical gaze and technical maneuvers necessary for them to have children. Thompson’s analysis of how patients willingly choose to be objectified in the service of technologized reproduction thus removes a burr that has long stirred cultural critics. It also suggests that patient agency will be key in the future spread of genetic screening and other technologies directed at having healthy offspring.

However, her category of “ontological choreography” is less successful. Yes, there are numerous steps of diagnosis, evaluation, hormonal stimulation, fertilization, and transfer that reproductive endocrinologists, nurses, embryologists, and patients must do in step to produce ART offspring. But many medical treatments involve intricate coordination among many health workers and patients. Providing adjuvant therapy to cancer patients may also be described as a dance among doctors, nurses, lab techs, and others to maintain the ontology or being of the cancer patient. But does describing these coordinated efforts as “choreography” really add anything to our understanding? Does her term “monopoly of desperation” describe a phenomenon that is notably different in ART than in persons faced with organ failure or cancer?

In short, health policy analysts may find less payback than effort in wading through a cultural studies monograph of a field that they know more familiarly in other terms. Thompson, however, does show us that the need for more centralized regulation of ARTS is much less pressing than critics of the field suggest. Inspired by the 1992
Fertility Clinic Success Rate and Reporting Act, the ART profession has helped develop a system that provides consumers with clinic-specific statistics for more informed market transactions. The profession has also played a role in reducing the previously high rate of triplets, and is cooperating in assessing the health of ART offspring. Even the President’s Council on Bioethics has grudgingly acknowledged that the ART space is not as infected with problems as critics had thought. With the United Kingdom’s Human Fertilisation and Embryology Authority now under parliamentary attack, the steam for a centralized licensing and regulatory agency in the United States is waning.

Thompson’s account of the “naturalization” of ARTS also suggests that future technologies of genetic screening, embryonic stem cell harvesting, and selecting the traits of offspring will also be “naturalized” into prevailing social and cultural narratives about the meaning of having and rearing children. Just as ARTs themselves have been assimilated into that narrative, so preimplantation genetic diagnosis and other techniques to ensure healthy or desired children will be naturalized as well. The fact that reproductive and genetic technologies are used to make parents and children will be much less relevant than the safety, efficacy, and distribution of them.

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