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Fondazione Alessandro e Tullio Seppilli (già Fondazione Angelo Celli per una cultura della salute) – Perugia

In copertina

Ambainde Tembini (Donoban, Ondugu, Mali), accanto ai suoi feticci. Qui Ambainde è intento a preparare delle piccole strisce di cotone: dopo aver raccolto su di esse qualche goccia di sangue della paziente, le inchioderà su un albero-altare, "fissando" su quest'ultimo il male. (Foto: © Roberto Beneduce, 2008)

Il logo della Società italiana di antropologia medica, qui riprodotto, costituisce la elaborazione grafica di un ideogramma cinese molto antico che ha via via assunto il significato di "longevità", risultato di una vita consapevolmente condotta lungo una ininterrotta via di armonia e di equilibrio.

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Editoriale

AM 52: Un numero "miscellaneo"

Giovanni Pizza
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Questo numero 52 di AM non ha sezioni monografiche e costituisce pertanto, come e forse più di altri, un carotaggio di ciò che la rivista è stata e intende essere: un periodico scientifico che pubblica scritti differenti orientati allo studio delle diverse culture del mondo contemporaneo e che hanno a che fare con questa fortunata branca specialistica dell'antropologia generale, l'antropologia medica. "Miscellaneo" è l'attributo che abbiamo dato, tradizionalmente, a questo fascicolo che raccoglie una varietà di temi e di autorialità, riconducibili, per diverse vie, all'antropologia medica italiana e internazionale, quella fondata, nel nostro Paese, da Tullio Seppilli nei primi anni Cinquanta del secolo scorso.

Piero Coppo, che purtroppo recentemente è venuto a mancare, è stato vicinissimo al nostro fondatore e a noi. Pertanto desidero manifestare la mia gratitudine a Laura Faranda, per avergli dedicato il saggio che apre questo numero "miscellaneo", non tanto come dovuto ricordo, quanto per affermare il grande contributo che Coppo ci ha dato. Desidero ringraziare anche Roberto Beneduce il quale, proprio in omaggio alla memoria di Piero, ci offre una foto del proprio terreno dogon che abbiamo posto in copertina, e sono grato molto a Eduardo Menéndez, maestro dal Messico dell'antropologia medica mondiale, del quale pubblichiamo la relazione tenuta alla prima presentazione di AM a Roma, in presenza, tra gli altri, del Presidente Siam, Alessandro Lupo, e della Presidente della Fondazione Alessandro e Tullio Seppilli, Cristina Papa.

Ho definito l'antropologia medica una subdisciplina "fortunata" perché lo penso: siamo stati veramente fortunati a incontrare sulla nostra strada persone del calibro di Tullio Seppilli e non ci scorderemo mai di ricordare il fondatore italiano di questi studi, al quale va la nostra memoria collettiva.

Si prosegue poi con le ricerche di Corinna Guerzoni, sulle narrazioni della fertilità e le loro articolate eterocronie, di Niccolò Martini sull'eutanasia, un tema attuale e complesso, di Marcela Perdomo, sui rituali di possessione in Honduras, argomento che andrà ripreso prossimamente anche per l'Europa, di Silvia Stefani, sul cosa ne è ora dell'accoglienza "a bassa soglia", durante la pandemia a Torino, di Gioele Zisa che, fra antropologia medica e religiosa, ben approfondisce una questione hittita che nei primi anni Ottanta del secolo scorso, fu testata, comparativamente da Alfonso Maria di Nola, e infine del medico Paolo Zuppi, che ora mette insieme diversi operatori per affrontare la questione clinica del rapporto medico-paziente in una chiave pienamente interdisciplinare.

Presentiamo poi recensioni ampie e articolate: sono il nostro modo per affrontare, pluralisticamente, il dibattito in questa disciplina specialistica, che in questo caso volge l'attenzione sia al momento della pandemia contemporanea da Covid-19 sia all'antropologia psichiatrica.

Speriamo così, anche con questo numero "miscellaneo", di avere offerto un ampio ventaglio di temi e problemi.

A presto e… Buon Anno 2022!

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Fertility Narratives: An Experimental Project of Applied Anthropology within a Fertility Clinic of Southern California

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Riassunto

Fertility Narratives: un progetto sperimentale di antropologia applicata all'interno di una clinica di fertilità californiana

L'articolo presenta un progetto sperimentale di antropologia applicata realizzato all'interno del WeHo Fertility Center (WHFC), un istituto di fertilità della California meridionale (2017-2020). A seguito di un periodo di osservazione presso il centro, ho proposto l'apertura di un laboratorio denominato *Fertility Narratives Lab*. Poiché l'infertilità non è stata quasi mai descritta come una malattia da medici e pazienti, ho proposto il concetto di narrazioni sulla fertilità, nozione principalmente ispirata alle narrazioni sulla malattia kleinmaniane, per fare riferimento a un insieme di narrazioni relative alla stratificazione temporale, emotiva e biopolitica dei percorsi riproduttivi. In questo articolo mi concentrerò solo sulla stratificazione temporale della riproduzione, mostrando tre diversi ambiti emersi durante il laboratorio: la temporalità corporea, la temporalità del personale e la temporalità dei pazienti.

Parole chiave: riproduzione medicalmente assistita, fertilità, fertility narratives, riproduzione, studi di genere, antropologia

Introduction[1]

This article presents an experimental project of applied anthropology realized within *WeHo Fertility Center* (WHFC), a fertility institute of Southern California. WHFC was founded in 2016 by Robert Paulson, a gynecologist who started this business after working for fifteen years in another clinic located in San Diego. Doctor Paulson opened WHFC with a specific focus on surrogacy; at the beginning, he started a collaboration with some worldwide fertility brokers and, after only one year, he inaugurated two

agencies directly linked to his clinic, defined "in house" facilities: *WeHo Egg Donors*, an agency for recruiting egg donors, and *WeHo Surrogates*, a society for finding surrogates. I conducted a research on US surrogacy at WHFC between September 2017 and February 2020, right during the development and expansion of Dr. Paulson's business. My research activities were directly linked to the context that I was studying, I mainly organized interviews with subjects involved in a surrogacy journey (egg donors, surrogates, and intended parents), by following them from the beginning of their in vitro fertilization (IVF) treatment until the delivery. At the same time, I worked to propose a project of applied anthropology. During the first year, after patients' consent, I requested to observe the first meetings between patients and clinical staff as I was interested in knowing how in vitro fertilization was explained by WHFC's employees. Many patients who used the services of by WHFC were internationals, from different part of the world, and most of them came from China, Israel, Australia, New Zealand, Finland, and Italy. Usually, those patients contacted the clinic through emails, followed by an initial Skype conference with Dr. Paulson, the WHFC's director, who requested to be involved in any first meeting. For this reason, Skype consultations were generally inserted within a flow of other numerous procedures, such as egg donors and surrogates OBGYN visits, embryos transfers and egg retrievals. In other words, the time devoted to those appointments was generally used as a "stopgap" among other procedures. To show how those interactions took place, I report below an ethnographic illustration that can be taken as an example of other Skype consultations that I observed at WHFC. Alma and James, an Australian couple, contacted WHFC for having information on surrogacy in California. As most patients, they sent an email through the website and booked an appointment with Dr. Paulson for 10:15. That morning, as many other days, Dr. Paulson was behind the schedule and at 10:15 he was still in the OR for an egg retrieval. It was at 10:35 that the secretary put in contact Dr. Paulson with Alma and James, and the Skype consultation started:

> Gynecologist: "Good morning and sorry for the delay. I am Dr. Paulson, and I am here to help you. What can I do for you?".
>
> Alma: "Good morning, Doctor. We want to have kids through surrogacy since we tried to conceive for so many years".
>
> Gynecologist: "How old are you?".
>
> Alma: "39".
>
> Gynecologist: "How many attempts did you do?".

Alma: "3 inseminations with stimulation and 3 IVF [in vitro fertilization]. We started when I was 33 and… […]".

Gynecologist: "We can try to give your eggs a try. Do you want one child or two children? Male or female?".

Alma: "[They look surprised by this question. They look at each other and waited some minutes before reply]. We haven't thought about it. We would like to have a child. But we don't know now if we want one baby or two, and we don't know about the gender yet. Can we choose it? How?".

Gynecologist: "At WHFC you can choose. Right after this Skype, one of my nurses will send you all the information via email. Now I will ask you some questions of your medical history, is that ok? I'm starting with you, Alma. Do you have any illness or medical condition?".

Alma: "No".

Gynecologist: "Do you take any medication?".

Alma: "No".

Gynecologist: "Any surgery?".

Alma: "No".

Gynecologist: "Do your parents or siblings have any illnesses?".

Alma: "No".

Gynecologist: "Are you allergic to any medications?".

Alma: "No".

Gynecologist: "Do you smoke or drink?"

Alma: "No".

Gynecologist: "Have you ever been pregnant?".

Alma: "No".

Gynecologist: "Have you ever had an abortion?".

Alma: "No".

Gynecologist: "Ok. The same question for your husband and I have all the information that I need".

I observed a lot of situations like the one reported above. After few months from my arrival at WHFC, I asked to interview patients right after first meetings to collect their impressions regarding the consultations. Many of them described a lack of empathy and especially they felt that their fertility history was not addressed at all. All the information collected during the first months of my ethnographic fieldwork brought me to propose the *Fertility Narratives Lab* to WHFC which I will describe in this essay. With fertility narratives, a concept inspired by illness narratives (KLEINMAN 1998) I refer to a set of narratives relating to the temporal, emotional and biopolitical stratification of reproductive paths. Since infertility is almost never described as a disease by doctors and patients, I propose this notion to collect in more

detail the complexity of the situations encountered. Considering the concept of fertility narratives, in this article, I will focus only on temporal stratification showing the point of view of all the subjects involved in a fertility treatment, mainly staff and patients.

Data and Methodology

The data collected in this article are the results of a long period of observation of first meetings and other interactions between staff and patients at WHFC from September 2017 until February 2020. The WHFC, opened only one year before my arrival at the facility, and it was a welcoming space for new ideas. I was perceived both as a researcher and as a colleague. Aware of the potential of the critical knowledge of anthropology that could have contributed to questioning specific practices, and how an anthropologist could help picturing and building new practices (or questioning some of them), I initially proposed a weekly meeting to employees directly involved in patients' treatments to focus on doctor-patient communications. WHFC's staff was composed by different professional figures, many of whom had direct interactions with patients: nurses, medical assistants, and third-party coordinators[2]. I organized those meetings as focus groups of one hour each. Every week, we discussed a different topic, such as patients' first consultations, the diagnosis of infertility, how to communicate the failure of specific treatments, how to address some specific issues, etc. After 7 months of participant observations, and mainly inspired by the concept of illness narratives, I proposed to the center to open a laboratorial space established on what I defined "fertility narratives", a concept that will be explained through this essay.

In/fertility: A Non-Visible Disease

According to World Health Organization (WHO) infertility is labeled as a disease (ZEGERS-HOCHSCHILD *et al.* 2017). Worldwide, this definition generated debates both within the scientific community and in patients' point of view. Literature has shown how the infertility concept not only vary from one social context to another (INHORN, VAN BALEN 2002), but how it is intertwined with the gender dimension (HINTON, MILLER, 2013; LINCONSTANT in GUERZONI, MATTALUCCI, *in press*) and how it changes throughout history (DAVIS, LOUGHRAN, 2017). Within the IVF arena, infertility depicted as a disease brings ARTs to be perceived as a cure. However, according to

some scholars, fertility treatments do not cure infertility per se – since they don't heal sick bodies – but instead they work more on improving patients' conditions and help their ability to produce babies (Lombardi 2018), mainly by replacing what doesn't work: eggs, semen, embryos, uterus, etc. There are known factors responsible for women's infertility, such as early ovarian failure, endometriosis, various problems related to ovulation (polycystic ovary syndrome), or fibroids in the uterus. Likewise, there are identified issues for men's sterility. Nevertheless, the cause of these problems is not always clear to specialists and in a lot of cases, infertility is described to relate to unknown reasons, many of which, however, are referred to the body's temporal deterioration.

In all the unknown cases, a progressive mapping of the solutions that could be used is carried out without a precise diagnosis. From a medical point of view, female infertility and male sterility are treated in different ways. Gynecologists are more cautious talking about female infertility stating that it is more difficult for them to predict women's response to hormonal stimulation and to other fertility treatments, while on the contrary, they represent male sterility as a medical problem that can be easily remedied (Barnes 2014) since even "one spermatozoid is enough" (Linconstant *in press*) to conceive. These representations, intertwined on how ARTs work, produce specific patients' imaginations regarding infertility, fertility, and reproductive treatments. According to the collected data, none of the patients involved in the study described their infertility as a disease, but more as a sophisticated interweaving of unknown factors that work against their ability to conceive, mostly related to having wasted their time when they could easily procreate[3]. In another work (2020), I focused on how fertility treatments are perceived by patients. Showing the way in which ARTs operate gave patients the impression of ivf as an extremely controllable practice (since it is possible to plan in detail every action), while it is impossible to make any sure prediction of possible results. The reproductive project develops in its contingent structure, and it is characterized by being constantly revised as the techniques may fail and the treatments may change; in that frame, patients' expectations expand over time and space (Guerzoni 2020). What it is sure, it is the impossibility to predict the success of any fertility treatment, if not from only a purely statistical point of view[4].

In the following paragraphs, I will introduce the fertility narratives lab showing how computational predictions and fertility rates are represented

both by IVF specialists and patients and focusing on how temporality plays a crucial role within the ARTs arena.

Fertility Narratives Lab: A Matter of Temporalities

Fertility narratives is a concept inspired by the illness narratives (Kleinman 1998). As I discussed above, patients involved in this and in my previous research (2012, 2014-2017) never referred to their inability to conceive as a disease. For the peculiarity of this condition, I decided to formulate the concept of fertility narratives, instead of illness, to embrace a plurality of experiences that go beyond the idea of infertility as a disease. With fertility narratives I refer to a set of narratives relating to the temporal, emotional and biopolitical stratification of reproductive paths and not exclusively to patients' awareness of their inability to conceive. Indeed, from the collected experiences during the fieldwork, I noticed that many of the patients arrived at WHFC after a variety of different fertility treatments received in other facilities. It means that those subjects lived through many reproductive failures and unsuccess and, from my point of view, fertility narratives concept could capture all those reproductive disruptions (Inhorn 2007) related to patient's experience. In the field of applied anthropology, the ideas that I had behind fertility narratives were 1) to collect information that normal consultations could not collect due to lack of time and 2) to offer a space for patients to make sense of previous experiences and connect them with those in progress.

As I mentioned, time turned out to be a crucial element for fertility narratives for several reasons. At the beginning of my fieldwork observations at WHFC, I noticed that the time was never enough, for consultations, visits, phone calls and skypes. Time insufficiency was mainly perceived by patients who declared to felt that all their needs were not addressed completely. At WHFC, there wasn't an official protocol for first consultations, even if Dr. Paulson asked to the front desk to schedule those meetings directly with him. According to my fieldwork notes and observations, the time dedicated to patients were considered, both by patients and by the staff, as not sufficient to collect all the information needed to start any infertility treatment. Indeed, skypes were generally followed by numerous emails to gather as much information as possible on patients' conditions. At the same time, patients expressed their dissatisfaction on this way of collecting information describing emails as a detached way of talking about sensitive issues,

as an excessive waste of time as replies were expected within 48 hours while many international patients reported weekly delays, and most important, patients represented emails as "cold and anonymous" way of communication for doctor-patient relationships. Helped by the staff who gave me the most fruitful information during the first step of this project of applied anthropology, I co-organized, only for specific types of patients[5], a space in which they may be able to "have time" and express what they experienced through their previous fertility treatments. One of the most salient aspects emerged during the fertility narratives lab was time.

One of main aspects emerged during the fertility narratives lab was time centrality. Temporality can be identified in different phases of an IVF journey: from the time invested in seeking information regarding reproductive pathways, to the period used to conceive (often months, if not years). From patients and staff, time has been described as a crucial feature to succeed and have positive results. As my findings collected within the fertility narratives lab shows, there is a stratification of temporalities which are composed by different dimensions and that I will divide below in three different scopes: body temporality, staff temporality and patients' temporality.

Body Temporality: Timing to Achieve a Pregnancy

In Western societies fertility is often associated with different images, and one of them is directly related to time. The biological clock is a common expression used to indicate the cruciality of time on reproductive bodies, indicating the need to reproduce before it is too late, and it is mainly used regarding the fertility of women and is almost never applied for men. The social representation of fertility sees female bodies as more exposed to temporal deterioration due to the aging of bodies compared to the male ones. It is not only the gender dimension that influences this representation, but also the way in which reproductive medicine, by mapping the inside of the bodies, has produced a specific knowledge on reproduction, underlining the fragility and scarcity of eggs compared to the male semen and calculating the "best time" to reproduce before "wasting time". Lucy van der Wiel, a scholar who has done extensive research on reproductive technologies and aging, showed «how notions of the 'biological clock' and related egg-focused decline-oriented understandings of female fertility contribute to a conceptualization of the non-reproductive body as a

figure through which fears about ageing can be articulated and produced» (2014: 4) and on how practices as egg freezing could help to conceptualize «traditional narratives of ageing as decline, but also trigger a public re-conceptualisation of age-related reproductive physiology through a focus on the ovum as the locus of fertility» (2014: 4). ARTs, highlighting how human fertility works, have an important impact on the way people perceive their reproductive capabilities both with certain limits but also with some boundaries to overcome, as bodies that have a timer and that can reproduce within a specific time window. ARTs expand this temporal dimension and «[…] despite biomedicalization, or perhaps because of biomedicalization tendencies, the women integrated perceptual and scientific knowledges to ascertain the "right time" to do it» (Mamo 2007: 176). The medical and technological intervention on pregnancy has produced a progressive and punctual knowledge of each phase of conception. It is possible to use several devices to track women' ovulations, from ovulation predictor kits to ultrasounds, and identify the right time to conceive. These tools tend to indicate specific time frames, on the one hand simplified the procedures and on the other hand maximized the possibility for success. Mamo described how throughout history the change on how women tracked their menstrual cycles from a self «experiential knowledge about their bodies» (172) – like body temperature and vaginal mucus – to «medical technology with standard procedures» (172) had a direct impact on how people represent conception, bodies, reproductive functions, and time transience. I argue that ARTs, and the knowledge that revolve around them, have progressively invested bodies and representations, giving enormous space to the temporal cruciality above other aspects.

Temporality is a fundamental element that also characterizes surrogacy, one of the most complex practices that develops through IVF. Surrogacy is characterized by several steps, and it touches a plurality of subjects, not only people physically involved with their bodies, or parts of itself, such as intended parents, gestational carriers, and sperm and/or egg donors. There are also many other specialists who take part in this process at different stages, such as embryologists, doctors, nurses, and third-party coordinators. Surrogacy's journey can be pursued using a fresh, a hybrid or a frozen cycle, in which the fresh cycle requires a more detailed coordination between parties compared to the other two forms that give way to a more capillary control of the patients' bodies by specialists[6]. At WHFC all the IVF procedures related to surrogacy were based on frozen cycles; this gave an imbalance on bodies' control in specialists' hands who were the only ones

who could determine when it was the correct time to proceed, an aspect that will be analyzed in the following subparagraph.

Staff Temporality

An IVF treatment is composed by numerous steps. In order to create embryos, two bodily substances are necessary: eggs and semen. In the cases observed at WHFC, sperm was mostly obtained through masturbation (collected in the so called "collection room")[7] and less with surgical tools; except for rare cases, no preparation of male bodies was required, other than a suggested three-day abstention before any semen collection. A different procedure is necessary for any eggs retrieval that can be only performed through surgery. Egg retrieval can happen only after daily injection of hormones, generally up to fourteen days. WHFC staff monitored patients' follicular maturation through blood analysis and transvaginal ultrasound. If semen collection could be done easily at any moment, egg retrieval occurred within a very specific time window.

WHFC staff represented some aspects of IVF as more crucial part for achieving a successful IVF program compared to other ones. Egg retrieval has been described by specialists as a decisive event, and through practices and words they educated patients regarding the importance of acting within a specific frame time. In many cases observed, more than one patient was asked to be ready for egg retrieval overnight, at a specific time, because according to the calculations of WHFC specialists, the "best eggs", namely the oocytes at their maximum development, were ready only in that specific moment. It was a matter of acting at the "right time" rather than waiting hours and wasting time and resources. According to nurses, waiting some hours could have influenced the egg's quality and with it, hypothetically, all the following steps. I collected several sentences about this time rhetoric from staff point of view, as for example, one day, all the embryologists were called for an emergency meeting in Dr. Paulson's office. The director of WHFC asked who was available to be in the Lab at three am for one of their oncologist patients. Stacey, twenty-four years old, started her chemotherapy before knowing that it could have affected her fertility. Thanks to a friend of her, she discovered the so called "oncofertility program" which consists in retrieving some eggs before any chemotherapy treatment. WHFC staff explained Stacey that her fertility has been already damaged since the ovarian reserve analysis, and the followed hormonal injections, showed

low response to treatments. The latest blood work done, and the transvaginal ultrasound showed that the follicular maturation was almost at its maximum stage. After this visit, Dr. Paulson programmed the egg retrieval when, approximately, the oocytes were supposed to be fully mature and at their best development. Stacey was asked to arrive thirty minutes before three am. That morning she arrived one hour earlier. I was there too. She confessed to feel nervous since the exam done in the afternoon showed only three possible mature eggs. While I was chatting with Stacey, one of the nurses arrived and told her:

> Thank God you are already here, better earlier than later, better to be here on time and before it is too late, sweetheart. We set up the room and we have just to wait the anesthesiologist. Hopefully without the LA morning traffic he won't be late. It is very important to retrieve your eggs this morning around three, they look perfect, and we need to retrieve them. We cannot waste this try. Everything is going to be ok, we organized it meticulously.

In this ethnographic example, like in the majority observed at WHFC, the staff expressed the importance of performing the egg retrieval "on time", not only for egg quality, but mainly because the procedure became necessary for the next steps of a larger project: the conception. Not collecting mature eggs meant delaying the journey and directly postponing parenthood. In Stacey's example, this was even more emphasized, as chemotherapy was already having a negative impact on her reproductive system, other than the flow of time. Retrieving the few eggs on time was almost represented as a mission for the staff.

Egg retrieval is one of first steps of a broader process. The eggs retrieved from an egg donor and or an intended mother can be immediately fertilized with semen from sperm donor/intended fathers, like in Stacey's case, or frozen to be used later. At WHFC all the embryos created through IVF were cryopreserved for several reasons. One of the most important ones was related to pre-implantation genetic diagnosis (PDG) and pre-implantation genetic screening (PGS). According to Dr. Paulson and his embryologists' staff, genetic screening information (available only for frozen embryos) could implement the chances of embryos' attaching to patients' uteruses since the quality of the embryo may affect its probability of having a so-called successful pregnancy[8]. Frozen embryo transfer (FET) was also described as less costly, and less phycological and physical stress on the woman's body. But one of the main reasons was because it was the easiest way to proceed and have more control on the IVF program. Indeed, while the embryos are frozen and stored at WHFC lab, female patients fol-

low a calendar made by nurses used to prepare their uteruses to receive a FET. This body's preparation takes time (up to three weeks), and it is composed by daily injections of two different types of hormones to help the endometrium reach a certain thickness and increase the chances for the embryos to stick. For FETs, patient's bodies preparations were monitored weekly through blood analysis and transvaginal ultrasounds. Unlike the egg retrieval, FETs weren't surrounded by the same apprehension related to proceed at a specific time, but they were generally scheduled on the same day so that staff could organize the OR for FET only.

The timing of reproduction was dictated by different screenings and by the availability of the center's specialists. Through words and thanks to the organization of procedures, the staff educates patients on the calculability and predictability of treatments. The idea of the right time, calculated, predictable and tamed by technologies, clashed with what patients required and hoped for on their own journeys. Below I report a conversation collected during a staff meeting:

> Rosie: "Patients need to be educated, on how IVF works, on how many steps are needed, on the timing to follow, on how to take meds and any possible response of their bodies. They often ask for everything right away, but bodies have their own time, and we are monitoring them through each fertility treatments. For example, eggs cannot be retrieved when they want. We must check where their follicles are at and book the egg retrieval when they are mature".
>
> Sonia: "Exactly, for the same reason we cannot do the FET when they want. Sometimes patients ask something that doesn't have any sense, like 'please, I want my baby an Aries, we need to make the embryo transfer before the end of this month' or 'I have time in December, I need to have my baby in this month'".
>
> Rosie: "Yeah, right? Our bodies work differently than our busy life. Yes, IVF may help, but there is a precise timing to follow. We really need to instruct them. It is important that they take meds on time, and they follow the calendar that we make for them. We know that there are other facilities that don't pay attention on meds, but for us it is. They cannot just schedule another transfer right after a miscarriage. The uterus needs to be prepared. I don't understand how other clinics do that".

WHFC staff insisted on the importance of following certain practices based on their knowledge and their experiences.

Patients' Temporality

Now that the beta (blood analysis) are positive, I am calm, but trust me, I felt like lost several times. When we started our last treatment here, I was calling the clinic like any other day. I felt like they weren't following us. My nurse said that I was too anxious, but I felt I needed to keep them on track, or they would have delayed my journey. If I hadn't contacted them, they wouldn't have called me. We were suspended, like suspended in time while the time was running fast. We needed to act as soon as we could.

> Patients – who had often arrived at the center following a long pilgrimage or who were at an "advanced" age to procreate and reproduce – were eager to conceive "before it was too late". The patients represented their previous experiences, as well as those in progress, as "suspended in time", characterized by an ephemeral perception of control and a constant uncertainty due to the way in which the ARTs operate and how procedures have been represented by the healthcare personnel. The processes organized within a specific time frame by the staff gave to patients the impression of being an extremely controllable technique (since it is possible to plan each action meticulously - like the egg retrieval at three am) while it escapes to any possible prediction. The reproductive project is expressed in its contingent structure and is characterized by being in constant revision since trajectories may change, techniques can fail, and expectations could expand over time (Guerzoni 2020).

During the meetings at the Fertility Narratives Lab, patients expressed many times what it could be described as "chasing time", namely reproducing before the time can cause a definitive halt to their reproductive abilities. As mentioned, many of them came from long and troubled journeys that had marked their lives. Brianna, an actress of 42 years old, described her reproductive journey as the cause of her Post-Traumatic Stress Disorder (PTSD) for having experienced a series of reproductive failures that have made her wasting time and hopes.

> I had like a PTSD from all the IVF treatments that I had in the past, I failed, my body failed, and we lost time. We experienced our journey as a race against time. We waited so many years before deciding to have kids, and then it was too late. Since then, every day is like a waste of time, a waste of money, energy, and hope. It was a weird sensation, after any treatments the time was like slowing down but at the same time, we knew that we were losing precious time, especially due to my age. My eggs were getting old at any minute, and it was so important to me to collect as many eggs as possible before it was too late. The doctor was very clear with us, we only had the 22% of chances.

Brianna, like other patients interviewed, showed how most of them experienced time as something that oscillated between slowness but above all towards an unstoppable speed that could have made every sort of reproductive project fail forever. "Chasing time" had a very complex meaning, and it wasn't only related to the need of acting "before it was too late". One of the most salient pieces of information collected with patients was their dissatisfaction on the time that WHFC staff dedicated them, especially during the first meetings described by most of them as crucial moment of their reproductive journey. Ashley, a real estate agent of 47 years old, said:

> I am happy that I can share my experience with someone. During the first Skype call that I had with Dr. Paulson, I felt weird vibes. Not sure how to say that, but it seemed that he didn't care at all and that he was like obligated to make this call rather than interested in learning how to help me. It was only 10 minutes, and I couldn't tell him all the things that I have been through.

In a similar way Luna, a sale assistant of 52 years old, told me:

> The first consultation was like some others that we had in the past in other facilities, in a rush. It seems that they don't have time to listen. The doctor just asked me how many kids I wanted, and he had not collected any information regarding all the tries that we had. After the consultation, we had been contacted by his staff and we received partial info. I mean, we wanted to receive some explanations about our infertility, but instead we received instructions to follow, mainly through emails.

Ashley and Luna, as many other patients involved in the fertility narratives lab, expressed disappointment about the insufficient time dedicated to their consultations, and in general in the collection of explanations from the staff. Patients felt a lack of time for sharing their experiences, especially because they thought that it could give to the staff a better understanding of their fertility situation. This topic is directly linked to another main theme emerged during the shared narratives between patients: the lack of a fertility history, as Luna mentioned. Her interview brings up more interesting information: WHFC staff was more focused on giving patients instructions to follow rather than dedicating time to a doctor-patient relationship. Following patients' perceptions, the time spent on treatments was mainly related to how to take the drugs, how to give the injections and less to situations they assessed as equally important, such as the time devoted to interviews, answering questions, listening to patients etc. From the conversations collected it emerged a clear predominance of the care of the technical aspects above all the others, like Robert, a bank clerk of 54 years old stated:

> It was a matter of numbers and treatments. During the first consultation, the doctor mentioned their success rates and said that his clinic was first ranked in the US. If I remember, he talked about an 83% success rates, which was insane to me. My wife and I went in 5 different clinics before arriving at West Hollywood Fertility Center, and none of them had this rate, they had the 40% max. Then we realized it was related to the proposed treatment. The doctor has been very honest with us, and he immediately proposed a surrogacy journey with an egg donation program. He said that we could have tried to make another try, but he believed that with my wife's condition we may had the 5% chances to get pregnant. With a surrogacy program he talked about 95% chances, and he calculated that we could become parents by the end of the year. You know, I am 54, my wife is 58, so we decided to use an egg donor and a surrogate.

Robert and his wife arrived at the center for an IVF treatment using both their gametes. They wanted to try again with their genes before understanding if they wanted to proceed further, but after the consultation with Dr. Paulson, in which he mentioned statistics and waste of time, they decided to use a surrogacy program to become parents as soon as possible.

A final important point to mention is related to the way in which patients interpreted the information received from the staff, below one example described by Francis, a psychologist of 37 years old:

> I don't know, it is like when you meet for the first time a patient. I say that for the job that I do. We need to learn how to understand each other. My nurse sent me several communications with sentences like 'we are going to start the journey *right away*' or 'we are going to make the FET *right away*'. For me, *right away* means immediately, or after some hours. After a while, I understood that *right away* meant in a week or some weeks. It is so frustrating.

This ethnographic example shows some difficulties of communication between staff and patients, statements which feed patients' hope, but above all their haste of chasing time. This type of communication, combined with the practices implemented by the staff, created in patients a specific imagery relating to reproduction, which would seem to be marked exclusively by the technicalities operated by the staff, but which escapes pre-established logics.

Conclusion: Restructuring Time

The fertility narratives lab was born with a dual purpose; on the one hand, to collect wider information on patients' fertility, on the other, to serve as a dialogic space between different voices, such as staff, patients, and me as

a researcher. This applied anthropology project, mainly designed to bring critical and reflective anthropological knowledge into a clinical context, has been particularly fruitful for collecting several facets of timing and reproduction within a fertility clinic. The establishment of the laboratory, although it had many favorable conditions, was not easy to achieve because the slow knowledge of anthropology clashed with the precise and frenetic timing of a fertility center.

Time has been a constant thematic of the Fertility Narratives Lab. From the collected narratives, time has emerged as one of the crucial aspects of ARTs for different reasons, and from different perspectives. In this article, I have highlighted three different temporalities collected during the fertility narratives lab. The first temporality described has been the time of the bodies, intended as a decisive factor for the deterioration of reproductive abilities, more in women than in men. The second mentioned has been the staff temporality, strongly focused on a specific organization of time based on previous staff knowledge and success rates that have implemented the idea of the need to act within a specific time window and avoid jeopardizing the success of the entire journey. The third, and last one, it was connected to patients' time perception that collided and shaped with the other two temporalities. IVF gives the impression of being an extremely controllable practice, since it is possible to plan in detail every action, when it escapes every possible prevision. The staff mainly described the respect of the execution of precise, albeit imprecise, manipulations of the "times of the bodies" – follicular maturation, egg retrieval, etc. – as fundamental actions for the success of any IVF treatment. From their point of view, the precise execution of these phases would have laid the foundations for a positive path; on the contrary, any change of program – even if minimal – could have compromised the success of the IVF. Patients eager to conceive before it was "too late", represented their experiences as "suspended in time", mainly characterized by a persistent uncertainty due to the way in which ARTs operate. While on the one hand, patients felt the need to "chase time" by asking to speed up the steps necessary to complete the steps necessary to achieve conception, on the other hand, the staff highlighted the importance of waiting for the "right moment" for the execution of the techniques. These representations fed the imagery of patients, who viewed in vitro reproduction as a highly controllable, manipulable, and predictable practice.

Fertility narratives can be seen as and proves to be an opportunity to find a politicized voice of fertility, but also to reflect on the way in which

reproductive bodies are represented. Fertility narratives as a theoretical concept help me to show how the time has been perceived and co-constructed between patients and staff. From the collected data, time was devoted more to technique practices rather than to listen to patients. Thanks to the critical knowledge of anthropology, and especially thanks to the information acquired during the fertility narratives lab, some practices given as praxis have been questioned by the staff. In a similar way, patients involved in the lab were able to reflect on their journey in a different way compared to their previous experiences gaining awareness on how the only certainty of IVF is its uncertainty.

In conclusion, I believe that fertility narratives – meaning the set of narratives relating to the temporal, emotional and biopolitical stratification of reproductive pathways – can offer a space for reflection both for the patients and for the staff, to approach the patients in a less mechanical way and embrace more the subjective dimension, without therefore seeing patients as body parts.

Notes

(1) All the names reported in this article have been changed to ensure the anonymity and protect the privacy of the subjects involved in this research.

(2) Third-party coordinators are assigned only to patients who use surrogacy to have children. Third-party coordinators are a liaison among patients and all the parties involved in a surrogacy journey, such as fertility lawyers, egg donors, gestational surrogates, insurance brokers, and OBGYN doctors.

(3) The average age of patients who used IVF and surrogacy at WHFC was around 43 years. On the website of the Italian Ministry of Health, for example, like in the majority of scientific database, it is highlighted the crucial role played by the time: «Fertility, both male and female, is affected by the normal aging processes of the organism, changing with age. In humans, the sperm production process does not stop with aging, but gradually decreases and deteriorates in quality, in relation to a gradual decline of the hormone levels and the appearance or worsening of various andrological diseases. In women, however, age plays a very important role in reproductive capacity. For an informed choice, it is important that young women are informed that the female ‘fertile window’ is limited, and that the quality of the oocytes decreases with increasing age. The fertility of women, therefore, is maximum between the ages of 20 and 30, then undergoes a first significant decline, albeit gradual, already around the age of 32 and a second fastest decline after age 37 […]» – https://www.salute.gov.it/portale/fertility/dettaglioContenutiFertility.jsp?lingua=italiano&id=4556&area=fertilita&menu=stilivita.

[4] International societies of reproductive medicine and fertility clinics show rates of success of specific practices based on different factors (age, quality of semen, egg and embryos etc.).

[5] The experimental project involved a period of testing and observation with respect to what I have defined fertility narratives. Weekly, exclusively European patients were selected to participate in this initiative which included a long interview between patients and third party-coordinators before the video consultation with Dr. Paulson.

[6] One example of a fresh cycle is the aligned of egg donor/or intended mother menstrual cycle with the surrogate one. An example of frozen cycle is preparing surrogate's uterus to receive a frozen embryo cryopreserved at the clinic.

[7] At WHFC this room was in front of the IVF lab. Inside of the collection room there was a sofa and a television with a large collection of porn available for patients. A medical assistant was generally accompanying patient inside this room, giving them some instructions to follow. When the patient collected the semen inside a cup, he had to call the andrology lab by ringing a bell.

[8] This information is shared not only by WHFC, but also by other fertility clinics and some latest articles on embryos quality and IVF success rates, such as, for example *Does Maternal Age at Retrieval Influence the Implantation Potential of Euploid Blastocysts?*, published in 2019 on the *American Journal of Obstetrics and Gynecology*.

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Scheda sull'Autrice

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Resumen

Fertility Narratives: un proyecto experimental de antropología aplicada dentro de una clínica de fertilidad de California

El artículo presenta un proyecto experimental de antropología aplicada realizado dentro de WeHo Fertility Center (WHFC), un instituto de fertilidad del sur de California (2017-2020). Dado que la infertilidad casi nunca fue descrita como una enfermedad por médicos y pacientes, propuse el concepto de narrativas de fertilidad, una noción inspirada principalmente en narrativas de enfermedad por Kleinman, para referirme a un conjunto de narrativas relacionadas con la estratificación temporal, emocional y biopolítica. de caminos reproductivos. En este artículo me centraré únicamente en la estratificación temporal de la reproducción, mostrando tres ámbitos diferentes que surgieron durante el laboratorio: la temporalidad corporal, la temporalidad del personal y la temporalidad de los pacientes.

Palabras clave: reproducción médicamente asistida, fertilidad, fertility narratives, reproducción, estudios de género, antropología

Résumé

Fertility Narratives: un projet expérimental d'anthropologie appliquée au sein d'une clinique de fertilité californienne

L'article présente un projet expérimental d'anthropologie appliquée réalisé au sein du WeHo Fertility Center (WHFC), un institut de fertilité du sud de la Californie (2017-2020). L'infertilité n'ayant quasiment jamais été décrite comme une maladie par les médecins et les patients, j'ai proposé le concept de récits de fertilité, notion principalement inspirée des récits de maladie de Kleinman, pour désigner un ensemble de récits relatifs à la stratification temporelle, émotionnelle et biopolitique. des voies de reproduction. Dans cet article, je me concentrerai uniquement sur la stratification temporelle de la reproduction, montrant trois portées différentes qui ont émergé au cours du laboratoire: la temporalité du corps, la temporalité du personnel et la temporalité des patients.

Mots-clés: procréation médicalement assistée, fertility narratives, reproduction, études de genre, anthropologie

Abstract

Fertility Narratives: An Experimental Project of Applied Anthropology within a Fertility Clinic of Southern California

The article presents an experimental project of applied anthropology realized within WeHo Fertility Center (WHFC), a fertility institute of Southern California (2017-2020). Since infertility was almost never described as a disease by doctors and patients, I proposed the concept of fertility narratives, a notion mainly inspired by illness narratives of Kleinman, to refer to a set of narratives relating to the temporal, emotional and biopolitical stratification of reproductive paths. In this article, I will focus only on the reproduction temporal stratification, showing three different scopes which emerged during the lab: body temporality, staff temporality and patients' temporality.

Keywords: assisted reproductive technologies, fertility, fertility narratives, reproduction, gender studies, anthropology