THE FERTILITY SHOW AS A FIELD-CONFIGURING EVENT: A CRITICAL DISCOURSE ANALYSIS

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"Your body is a battleground."

Barbara Kruger

THESIS ABSTRACT

This thesis explores how Field-Configuring Events (FCEs) discursively maintain field legitimacy. It particularly addresses how organisations within the field of fertility treatment employ discourses of the female non-reproductive body at one of the field's FCEs, the Fertility Show.

FCEs are temporally and spatially bounded events where organisations belonging to the same field meet and share collective understandings of issues relevant for field-level activities. Despite being acknowledged as important loci for field configuration and legitimacy (Lampel and Meyer, 2008; Wooten and Hoffman, 2016), FCEs are still relatively understudied phenomena. This research particularly addresses the gap of how discourse is generated and employed at FCEs (Hardy and Maguire, 2010), specifically towards legitimacy. It sits within an academic discussion that sees a number of empirical studies concerned with the discursive analysis of legitimacy (Vaara et al., 2006; Alvesson, 1993; Brown, 1998), but a critical perspective to the analysis of discourse is rarely taken (Vaara et al., 2006; Barros, 2014). The thesis contributes to this discussion by adopting a Critical Discourse Analysis (CDA) approach to unveil discursive strategies of legitimacy employed at the FCE to maintain field legitimacy. As a dynamic and on-going process (Deegan, 2002; Suchman, 1995), legitimacy needs to be maintained (Shocker and Sethi, 1974). Scholars acknowledge that FCEs can work towards field maintenance (Schüssler et al., 2014), however studies that discursively investigate this process and its implications for legitimacy are missing. The importance and peculiarity of FCEs represent a compelling case for analysis, and for empirical and theoretical expansion in this regard.

This thesis importantly also focuses on the concept of the body within organisation studies, and zooms in on the female body in particular. With respect to this literature, works so far have mostly analysed the body at work. The study shifts the attention from the body of the worker to the body *per se*, as a product, tool, and entity in its own right. Finally, this thesis brings to the fore how the female body is constructed within the organisational domain when it is not reproducing. By doing so, it expands our knowledge and balances our discussions as to how the female body is understood when non-reproductive or infertile.

The thesis is based on a qualitative study of organisations within the field of fertility treatment in the UK, and entails the critical discourse analysis of organisational texts collected at the

Fertility Show, here understood as a FCE. The study critically investigates how organisations discursively construct the female non-reproductive body; which relations they put in place between themselves and the bodies they construct; and how such bodies and relations discursively maintain the field's legitimacy at the FCE.

The analysis shows that organisations at the Fertility Show construct three discourses of the female non-reproductive body, and that each discourse engenders an imbalanced relation between the organisations and the female body. It further shows that each discourse and relation is rooted in past discourses on womanhood and motherhood, which are not explicitly employed by organisations at the FCE. Further, the research illustrates that, in this setting, organisations maintain field legitimacy through the discursive strategies of adaptation to social norms, reiteration of past discourses, and temporary interruption of social norms. At the FCE, legitimacy is thus sustained by adapting to current social norms on motherhood; by reiterating broader historical discourses on the female body; and by temporarily interrupting the current social norm that views infertility as taboo.

Building on the term 'discursive space' from Hardy and Maguire (2010), the study further contributes to our knowledge of discourse and FCEs by showing that FCEs can be approached as open discursive spaces where imbalanced relations are generated through discourse. It illustrates that FCEs are open spaces because, while they are temporally and spatially bounded, the discourses employed therein are not. The analysis shows that past discourses are employed at the FCE to maintain legitimacy, but not explicitly so. This in turn makes resistance hard to carry out.

The study further contributes to how we methodologically approach FCEs by applying a CDA approach to the study of discourse within FCEs. Particularly, a CDA approach explicitly shows that discourse can foster legitimacy through the creation of imbalanced relations between text producers and text consumers. This in turn brings to the fore issues of power, struggle, and resistance within and outside of the FCE.

With respect to organisation studies centred on the female body and reproduction, the thesis highlights how fertile bodies and infertile bodies exist in a dualistic system of societal and organisational expectations that cannot be simultaneously satisfied. Consequently, the female body finds itself locked in a lose-lose situation with regards to its reproductive choices, within and outside of organisational life.

PUBLICATIONS DECLARATION

The following publication relates to, and arises from research carried out for this PhD:

1. Cervi, L. (2016). The Business of Assisted Reproductive Technologies. A Research Agenda. In Grosser, K., McCarthy, L., and Kilgour, M. A. (eds.) *Gender Equality and Responsible Business. Expanding CSR Horizons*. Sheffield: Greenleaf Publishing.

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Table of Abbreviations and Acronyms

FCE	Field-Configuring Event
ARTs	Assisted Reproduction Technologies
IVF	In-Vitro Fertilisation
NHS	National Health Service
WHO	World Health Organization
NGO	Non-Governmental Organisation
HFEA	Human Fertilisation and Embryology Authority
IN UK	Infertility Network UK
BMA	British Medical Association
COTS	Childlessness Overcome Through Surrogacy
ACE	Association of Clinical Embryologists
ABA	Association of Biomedical Andrologists
BAS	British Andrology Society
BICA	British Infertility Counselling Association
FINRRAGE	Feminist International Network in Resistance to Reproductive Genetic Engineering
ALDU	Association of Lawyers for the Defence of the Unborn

CHAPTER 1. INTRODUCTION

1.1. Thesis Focus and Relevance

This thesis investigates how organisations at a Field-Configuring Event (FCE) discursively maintain field legitimacy. It particularly focuses on the field of fertility treatment and the Fertility Show as one of its FCEs, and analyses the discourses of the female non-reproductive body.

Within organisation studies, the concept of legitimacy is related to society's approval of an organisation's existence and activities (Shocker and Sethi, 1974), and needs to be maintained throughout an organisation's life (Shocker and Sethi, 1974). With regards to organisation studies concerned with the body, legitimacy allows us to examine how organisations employ constructions of the body to keep the field they belong to socially accepted and acceptable, hence legitimate. Within a field, organisations "involve themselves with one another in an effort to develop collective understandings regarding matters that are consequential for organizational and field-level activities" (Wooten and Hoffman, 2008: 138).

FCEs are important tools for field configuration and legitimacy (Oliver and Montgomery, 2008), and are created around a particular issue, technology, product or service (Lampel and Meyer, 2008). They take place at a specific public space and at a specific time, and are characterised by a) a set of groups of organisations that are bonded by similar interests or other common grounds; and b) the fact that these organisations will express their opinions with regards to the issue(s) they are dealing with (Oliver and Montgomery, 2008). Importantly, FCEs provide opportunities for novel or uncommon

interactions that can influence the field (Hardy and Maguire, 2010).

However, FCEs are still a relatively understudied organisational phenomenon. Specifically, to date we do not have much knowledge as to how discourses are generated and employed at FCEs (Hardy and Maguire, 2010), particularly with regards to issues of legitimacy. Whereas we do know that FCEs play a role in field legitimacy (Lampel and Meyer, 2008), the extent to which they do so through discourse is relatively still unexplored. Further, scholars concerned with the analysis of discourse through text production, distribution and consumption call for the inclusion of text consumers in our analyses (Hardy and Maguire, 2010). Empirical studies into discursive legitimation have mostly focused on processes of legitimation (Vaara et al., 2006) and on how discourse is employed when organisational legitimacy is explicitly threatened or needs repairing (see Patriotta et al., 2011; Elsbach, 1994; Phillips and Malhotra, 2008).

FCEs provide opportunities for studying how fields form and change, which in turn entails questions of legitimacy (McInerney, 2008). However, scholars have so far focused on FCEs as loci for field configuration rather than legitimation (McInerney, 2008; Anand and Jones, 2008; Glynn, 2008; Lampel and Meyer, 2008; Garud, 2008), despite the acknowledgment that FCEs can work towards field maintenance, which in turn creates implications for legitimacy (Schüssler et al., 2014). In this regard, FCEs can provide valuable venues for further empirical research on discursive legitimacy by focusing on discursive strategies of legitimacy maintenance. There are two reasons for this: 1) because the presence of a FCE entails that some level of field legitimacy has

already been obtained, the analysis of discourse at the FCE can focus on maintenance rather than obtainment or repair; and 2) whereas studies of processes of discursive legitimation tend to focus on *how* legitimacy manifests through discourse, analysing legitimacy maintenance gives additional insights into *why* discursive strategies are legitimate and maintain field legitimacy.

In order to explore these issues, this thesis specifically analyses the organisational field of fertility treatment, the Fertility Show as one of its FCEs, and how discourses of the female non-reproductive body are employed by organisations attending the Show. Analysing how organisations maintain legitimacy is relevant to organisation studies also in light of scholars' acknowledgement of the organisational need for social legitimacy to exercise power (Fox and Fox, 2004). Despite a number of accounts of how organisational practices on the body are used to exercise power (see Townley, 1993; Burrell, 1984), scholars within organisation studies have largely focused on the body of the worker or of individuals occupying organisational roles (see Harding, 2002; Cockburn, 1991; Hockey and Allen-Collinson, 2009; Hansen et al., 2007). By moving the analysis of the body outside of the workplace, this thesis examines how organisations at a FCE construct the body they will intervene on, and how they use such constructions to legitimise the field they belong to. The research thus aims to shift the focus from the body *within* the organisation to the body *per se*, as a product, tool, and entity in its own right. This shift is relevant because organisations' constructions of the body can be used to legitimise organisational fields at the broader social level.

The body has been described as an unfinished project (Shilling, 1993), a contested terrain (Grosz, 1995), and is

undoubtedly at the centre of much organisational focus: fashion, sport, and medicine are but a few sectors entailing organisations and businesses primarily concerned with the body as a locus of organisational intervention. Within organisation studies, in the past 20 years the body has become more explicitly the centre and starting point of analyses and reflections. Following the steps of what has been called the 'sociology of the body' (Shilling, 1993), a growing number of scholars have contributed to our understanding of the body in relation to organisational life. This is particularly noticeable with regards to the employee's body at work: how is the worker being physically and mentally controlled by the organisation? Is their body a mere tool to achieve higher profits? These reflections further developed within organisation studies into analyses of women's bodies and the lived experience of the body-subject: this was greatly due to the growing influence of feminist and postmodern scholarship on the social sciences (Turner, 1991; Hancock et al., 2000; Featherstone et al., 1991; Foucault, 1975; 1978; Butler, 1990; 1993; Irigaray, 1985).

To date, within organisation studies the body has been understood in its sensorial dimension at work (Hockey and Allen-Collinson, 2009; Gatta, 2009; Sennet, 2008), in its surface and aesthetics (Hansen et al., 2007; Tyler and Abbott, 1998; Hancock and Tyler, 2000; Brunner and Dever, 2014; Wolkowitz, 2002; 2006; 2011), in its gendered constructions in the workplace (Acker, 1990; Cockburn, 1991; Collinson and Hearn, 1996; Kerfoot and Knights, 1993), and as a locus of control and resistance (Brewis, 2001; Knights, 2014; Townley, 1993; Dale, 2005; Hope, 2011; Tretheway, 1999; Hancock and Tyler, 2008; Hall et al., 2007). Further, many scholars began investigating agency rather than the social construction of the

body, and more accounts emerged on how workers lived and understood their bodies within the organisation. Traditionally, organisation scholars concerned with the body have conceptualised it as an organisational input, and specifically concentrated on the working body. A strong analytical and conceptual focus is present in relation to the body as directly involved with the organisation, either as an employee, a consumer, or a customer.

In this thesis, I focus on human reproduction as a domain that explicitly positions the body at the centre of its concerns. The specific body I base my investigation on is the female non-reproductive body, in that it is a body where organisational intervention is needed for it to become reproductive, and where the production and reproduction of bodies takes place. This thesis thus centres around the concepts of the body within organisation studies, with a further focus on studies on the female body informed by feminist scholarship.

With regards to reproduction, the female body has been analysed by a rich corpus of feminist literature that questions and challenges the gendered social expectations in relation to motherhood and fertility (Longhurst, 2001; Swann, 1997; Hunter and O'Dea, 1997; Martin, 1990; Pfeffer, 1987; Shaw, 2012; Moore, 2010; Rose, 1987; Squier, 1996; Bacchi and Beasley, 2002). Reproduction and reproductive technologies have been understood by feminist scholars as either liberating or oppressive: liberating because of their potential to foster equality in the public and private sphere (Firestone, 1970), oppressive because of the acknowledged power of science and medicine over the female body (Rose, 1987; Martin, 1990; see also Harding, 1991). Women's bodies have been traditionally seen as 'unruly' in contrast to men's "self-contained,

autonomous" bodies (Longhurst, 2001: 85). This is particularly evident within women's reproductive lives where definitions of what is to be considered normal or dysfunctional have been shown to largely depend upon social constructions of gender as well as power relations and social expectations (Turner, 2008; Martin, 1990; Pfeffer, 1987). The female body thus represents a locus where these expectations are constructed, challenged and disrupted: reproductive medicine happens on and through the female body and it is thus a relevant area of enquiry for organisation studies concerned with constructions of the body and legitimacy. When involved in women's reproductive lives, organisations' quest for legitimacy is closely related to social norms and expectations in the matter.

Within the narrower focus of organisation studies concerned with the female body and reproduction, organisation scholars have analysed the female reproductive body in relation to organisations and looked at pregnant bodies at work; issues of maternity and parental leave; and questions of work-life balance (Gatrell, 2007; 2011; 2013; Brewis and Warren, 2001; Buzzanell and Liu, 2007; Mäkelä, 2005; Haynes, 2008a; 2008b; Cockburn, 2002; Corse, 1990; Gueutal and Taylor, 1991; Halpert et al., 1993).

However, within this stream of work, the female body is assumed to be fertile, maternal, and mostly directly involved with the organisation by being an employee. Thus, the organisational focus on the body is maintained within the organisation (Malenfant, 2009; Halpert et al., 1993; Cunningham and Macan, 2007). The reproductive female body is analysed primarily when employed by the organisation: in this regards, scholars have examined and noted the discrimination against maternal and pregnant bodies in the

workplace (Buzzanell and Liu, 2007; Cunningham and Macan, 2007; James, 2007; Edwards, 1996). Little attention has been paid to female bodies that a) are not necessarily undertaking an organisational role; and b) are non-reproductive.

Focusing on the female body matters for two reasons: first, because it is a body that engenders critical reflections not only when it is reproducing or is already maternal and/or in relation to the workplace. It is at the centre of social and gendered expectations also when it is unable to reproduce and meet societal expectations of motherhood. This scenario is explored in this thesis, where the role of the organisation in relation to the body is still central, but is also shifted: instead of being analysed as the fertile body's employer, the organisation is here analysed by virtue of its ability to operate on and through the non-reproductive body in order for it to reproduce and become a maternal body. Second, the focus on the female non-reproductive body matters because the body at the centre of organisational activities is one into which organisational intervention is *needed*: the maternal body is conceived as problematic in the workplace, but when the same body is not reproducing, the involvement of an organisational field, thus of a number of different organisations, is encouraged. In contrast to most of the work within organisation studies, this thesis does not investigate the non-reproductive body *at work*, but rather focuses on how such a body is constructed by the organisations that will intervene in it through their practices, be they services, products, or treatments. These organisations thus belong to the same field, that of fertility treatment, and regularly meet at one of the field's FCEs, the Fertility Show.

Within organisational settings, the body has been primarily analysed with respect to single organisations or occupations

(Leslie, 2002; Sennet, 2008; Hall et al., 2007; McDowell, 1997) thereby limiting investigations on the body to very specific settings. In this thesis, the analysis zooms out from the single organisation or occupation and reaches the broader level of the organisational field. Within organisation studies, an organisation field is acknowledged as being particularly central to the analysis of "social systems and processes" (Scott, 2008: 223). Within a field, organisations interact with each other and create shared understandings of the issues and concepts that are central for the field's activities (Wooten and Hoffman, 2008; 2016).

In order to analyse how organisations within a field construct such 'collective understandings', this thesis specifically looks at how organisations within the field of fertility treatment employ discourses of the female non-reproductive body to maintain legitimacy. The landscape of fertility treatment is, indeed, a fertile one for understanding how the body is constructed and understood by the variety of organisations whose existence is closely related to the female non-reproductive body. The organisations involved in reproduction and reproductive technologies are in fact not only medical, but encompass civil society, businesses, and the government. In the UK, fertility treatment only started to be regulated in 1990 with the Human Fertilisation and Embryology Act, after the publication of the 1984 Warnock Committee Report expressing public concern with respect to the ethics of reproductive technologies. The relatively late public preoccupation with fertility treatment allowed for private clinics to flourish in an organisational field that has since 1978 greatly expanded.

Fertility treatment thus represents a flourishing area of organisational life that biologically creates bodies by materially intervening in existing ones. This thesis seeks to examine how organisations involved with the female non-reproductive body create social understandings of it, and thus if and how they influence what it means, for instance, to be an infertile woman. Here, the female body is of particular importance in that the outcome that the field aims for (a live birth) is inevitably dependent upon the material existence of such a body.

In fact, fertility treatment is giving the opportunity to more and more women to become mothers when it is otherwise naturally difficult. The field does this by primarily acting on or within a female body that is struggling to conceive. The inability to become pregnant and deliver a healthy baby might be due to pre-existing medical or social conditions, or to unexplained factors (HFEA, 2016a). Medical advancements allowed for Louise Joy Brown, the first test-tube baby, to be born on the 25th July 1978 in England: since then, technology has progressed and the list of available diagnosis tools and treatments has grown to a wealthy set of choices for whoever wishes to access treatment, often at a high financial and emotional cost. Clinics and medical organisations are not the only actors in this scenario: the UK government, for instance, provides to-be-patients and patients with extensive legislation, regulation, and information about fertility treatment in the country. Further, a number of NGOs have become important points of reference for people who are struggling to conceive; some of the main UK fertility professional associations are very active in providing the public with information and support, too. Finally, private actors, such as clinics and pharmaceutical companies providing funding and support to NGOs and

professional associations, also play an important role in the delivery of services to the non-reproductive female body.

In the UK, the field of fertility treatment provides a valuable example of an organisational field where multiple organisations that deal with the creation of bodies through the female body come together at a FCE: the Fertility Show. An organisation field can evolve and be shaped by FCEs, which are "social microcosms" (Lampel and Meyer, 2008: 1030) characterised by a multitude of organisations that "express joint or independent sets of ideas and opinions regarding the issue they are dealing with" (Oliver and Montgomery, 2008: 1150) in a public setting, and at a designated time and space. Within the field of fertility treatment, I analyse the Fertility Show as one of its FCEs. The Show takes place in London (and, from 2017, in Manchester too) over two days and it is aimed at people who are 'struggling to conceive' (Fertility Show, 2016). The inability to conceive in fact presents multiple realities: same-sex couples, single women, 'older' women, and infertile women (either for unexplained infertility or related to medical conditions) all may 'struggle to conceive', but their realities, needs, and bodies are very likely to differ from one another. Some of these women might be fertile and in search of a sperm donor, or might be both patients and donors themselves. This is why I have analytically grouped this multitude of bodies under the term 'non-reproductive female body'. Through the analysis, I will address the non-reproductive female body as 'prospective patient', because that is the status of most people attending the Show: they can get involved by undergoing treatment or by donating (either eggs or embryos). In either case, should they decide to do so, they will potentially be involved as patients.

The Fertility Show hosts up to 80 exhibitors, or 'fertility experts', and up to 50 seminars are given throughout the two days on fertility-related topics. Exhibitors include a diverse set of organisations, such as private clinics, businesses, Non-Governmental Organisations (NGOs), professional associations, and the government. The various organisations and experts all offer products, services and consultations related to fertility treatment.

In light of the current status of the literature on organisational fields, FCEs, discourse and legitimacy; organisation studies and the body; and, within the latter, of organisation studies and the female reproductive body, this thesis addresses the following research gaps:

a. Within organisation studies concerned with organisational fields and FCEs, scholars note a gap in our understanding of how discourses are generated at FCEs, and stress that little attention has been paid to the discursive analysis of text consumers (Hardy and Maguire, 2010);
b. Further, we know that FCEs play a role in field maintenance, and that this has implications for legitimacy (Schüssler et al., 2014), however to date studies that address how FCEs can maintain the legitimacy of the field are missing. Analysing how discourse influences legitimacy maintenance at the FCE provides opportunities to address this gap.
c. Within the current literature on organisation studies and the body, scholars have encouraged further exploration of those bodies not directly involved with the organisation as empoyees, customers or consumers, but that are nonetheless influenced by the organisation

by being receiver of organisational services (Wolkowitz, 2011). This is done here by: 1) shifting the focus that views organisations as employers of the body to being the ones intervening in the body as a central feature of their existence; and 2) by examining an organisation field rather than single organisations. This choice allows me to investigate an organisational influence on the body that is less direct than that of a single specific organisation, but that is nonetheless present and relevant.

d. Finally, within the literature on organisation studies and the body there has been growing interest in the female body particularly with regards to its gendered construction and within the more specific focus of reproduction and pregnancy (Gatrell, 2011; 2013; Mäkelä, 2005; Halpert et al., 1993; Warren and Brewis, 2004). This thesis addresses the absence of studies of organisations and female non-reproductive or infertile bodies. Reproduction and reproductive health nonetheless include infertility, which is a domain that has so far received little attention from organisation scholars. Within the organisational domain, expectations of motherhood are also present when the female body is not reproducing.

1.2. Conceptual Toolkit

This thesis examines how FCEs discursively maintain field legitimacy, and particularly analyses the field of fertility treatment, the FCE of the Fertility Show, and discourses of the female non-reproductive body. The conceptual toolkit I employ thus entails the concepts of legitimacy, organisational field, field-configuring event, and discourse.

Within the organisational domain, legitimacy refers to the social acceptability and acceptance of an organisation's existence and activities (Shocker and Sethi, 1974). As an on-going process and a dynamic concept (Suchman, 1995; Deegan, 2002), legitimacy can be pragmatic, moral and cognitive (Suchman, 1995), and can be gained, maintained, and/or repaired (Elsbach, 1994; Phillips and Malhotra, 2008; Phillips et al., 2011; Vaara et al., 2006). Scholars have acknowledged the value of a discursive approach to the study of legitimacy and of related organisational phenomena (Alvesson, 1993; Brown, 1998; Vaara et al., 2006; Phillips et al., 2004; Hardy and Maguire, 2010). I particularly look at how the legitimacy of an organisational field can be maintained through discourse by analysing a field's FCE. This is done because the FCE at the centre of my analysis, the Fertility Show, was created in 2009 – almost forty years after fertility treatment emerged as an organisational field in 1978. It is thus unlikely that the FCE emerged to legitimise a well developed field; nonetheless, once obtained legitimacy needs to be maintained (Shocker and Sethi, 1974; Suchman, 1995), and FCEs are important loci to understand how this happens (Lampel and Meyer, 2008; Schüssler et al., 2014).

Within organisation theory, a field is a "central construct" (Greenwood et al., 2011: 334) which allows the investigation of "social systems and processes" (Scott, 2008: 223). Within a field, organisations interact with each other to create common and shared understandings of concepts that are "consequential for field-level activities" (Wooten and Hoffman, 2008: 138). These "collective understandings" (Wooten and Hoffman, 2008: 138) are important to legitimise organisational activities that include the female body, in that organisations within the field

of fertility treatment will share constructions of it that will render their activities on the body socially accepted and acceptable. The process of making a practice socially acceptable is linked to the concept of legitimacy.

One of the steps organisations can take to maintain their field's legitimacy is that of taking part at a FCE. Specifically, a FCE both configures and legitimises a field, and is defined as a setting where various organisations periodically meet to discuss and interact around a specific issue, service or product relevant to the field (Lampel and Meyer, 2008). A field, then, can be studied in its legitimacy through the lens of the FCE. Organisation scholars have acknowledged the salience of discourse and discourse analysis in the investigation of organisations, fields, and institutions (Phillips et al., 2004). Hardy and Maguire (2010) particularly note how FCEs can be viewed as discursive spaces that might influence field change, and stress that little is still known as to how discourses are generated at FCEs. Importantly, the spatial and temporal boundaries of FCEs make them a compelling case to analyse how discourse is employed towards the maintenance of field legitimacy.

In this thesis, the approach taken to discourse and discourse analysis is based on the work of Michel Foucault (1972; 1978) and Norman Fairclough (1989/2001; 1992; 1995). Foucault defines discourse as "practices which form the objects of which they speak" (Foucault, 1972: 49). Discourse does not take place in isolation, but in positive discursive relations among different actors and institutions. These relations are in turn historically contextualised and constituted by objects of discourse: in this regard, it is important to understand why and how certain objects of discourse have

emerged and developed. This requires an inquisitive look into the relations and social conditions that constituted the background for certain discourses to be born.

In order to explore how the legitimacy of the field of fertility treatment is maintained through a FCE, I analyse the discourses that organisations employ therein. The approach taken to discourse analysis is Norman Fairclough's Critical Discourse Analysis (CDA) (1989/2001; 1992; 1995a). Within discourse analysis, CDA is particularly focused on providing a critical analytical perspective on discourse so as to unveil and challenge power relations (Fairclough, 1993).

Organisation scholars have looked at the body within the organisation, but studies that explicitly focus more broadly on organisational fields are lacking. When applied to organisations and the body, the concepts of field, legitimacy, and discourse are significant for three reasons: 1) they allow for the investigation of a variety of organisations operating in the same field and in relation to a very specific type of body; 2) analysing a field brings forward underlying conceptions of a female body at the centre of the activities carried out by all organisations belonging to the field; 3) the study of the legitimacy of a field through the FCE lens unveils how legitimacy is maintained beyond the single organisational setting or profession, and the specific discursive strategies organisations employ to this end. These dynamics in turn clarify how organisational activities and practices on the female body are maintained as legitimate at the social level beyond organisational boundaries and the field.

1.3. Research Questions

In light of the above points, this thesis is concerned with the following question:

How do Field-Configuring Events discursively maintain field legitimacy?

The thesis particularly analyses the field of fertility treatment, the Fertility Show as one of its FCEs, and the discourses on the female non-reproductive body employed by organisations therein. Thus, the study is further guided by the following research questions. Within the field of fertility treatment, at the Fertility Show:

1. How do organisations discursively construct the female non-reproductive body?
2. What relations are discursively constructed between the organisations at the Show and the constructed bodies?
3. How are these bodies and relations maintaining field legitimacy at the FCE?

This study thus examines how organisations at a FCE employ discourses of the female body to maintain field legitimacy. It aims at broadening our knowledge as to how discourse can be employed to maintain legitimacy in a specific organisational setting. FCEs are spatially and temporally bounded, and provide opportunities for uncommon and novel interactions to emerge (Hardy and Maguire, 2010). These characteristics suggest that discourse, too, might operate in specific ways towards the maintenance of field legitimacy.

Further, these questions are significant for organisation scholars interested in the body in that they allow the analysis to focus on a set of organisations operating on the same type of body on a very explicit and material way. The questions also allow for broader understandings as to how discourses of the body are used to legitimise not just the activities of a single organisation, but of an organisational field altogether.

The research questions are addressed through the study of the field of fertility treatment in the UK and the Fertility Show as an FCE. In order to understand how the field gained legitimacy, I provide a historical account of the field's development starting from the birth of the first baby born thanks to In-Vitro Fertilisation (IVF) in 1978 – a key year for reproductive medicine. I present how organisations within the field came to life following the public anxiety the first test-tube baby created within UK society, how we arrived at the creation of the Fertility Show in 2009, and how organisations in the field gained legitimacy.

The Fertility Show is the empirical case used to understand how the FCE maintains field legitimacy. Here, the aim is to understand which discourses of the female non-reproductive body are employed at the Show, and how such discourses are used to position organisations in relation to the body. In order to do so, I provide an analysis based on my attendance of the Show in 2013 and 2014. Here, I collected organisational texts and attended a number of seminars. Data were then analysed through Fairclough's CDA framework: this entails three levels of analysis, namely text analysis, discourse practice, and social practice (Fairclough, 1989/2001; 1992). The levels employed to investigate how organisations construct bodies and relations are text analysis and discourse practice. Text analysis particularly shows which discourses organisations construct and employ in their texts, whereas discourse practice illustrates how such discourses are used by organisations to position themselves in relation to the female non-reproductive body. Social practice is instead concerned with explaining why such bodies and relations maintain field legitimacy by socially and

historically contextualising the research outcomes of text analysis and discourse practice.

Table 1. Levels of Analysis and Analytical Aims

Level of Analysis	Analytical Aim
Text Analysis	To investigate the discourses of the female non-reproductive body organisations employ in their texts at the Fertility Show.
Discourse Practice	To investigate how organisations at the Fertility Show use such discourses to construct relations between themselves and the female non-reproductive body.
Social Practice	To examine the historical and social reasons for the legitimacy of bodies and relations which emerged from text analysis and discourse practice.

1.4. Structure of the Thesis

Chapter 2 presents a review of the literature and is divided into four sections, each presenting an area of organisation studies, the current state of the literature, and the identified gaps that the thesis addresses.

The first section introduces the conceptual framework employed to answer the research questions, and focuses on legitimacy, discourse, organisational fields, and FCEs. Specifically, legitimacy allows to understand how an organisation can come to be socially accepted and acceptable; discourse is viewed as constitutive of organisations and power relations, and is an important analytical tool to examine legitimacy; the concept of organisational field shows how

multiple organisations can share the same understandings with regards to the activities they perform, and is particularly valuable when analysing discourses aimed at legitimising the activities of multiple organisations involved with the same type of body; and FCEs are important, yet understudied, loci for field configuration and legitimacy.

The second section introduces critical feminist literature on reproduction. Here, the female body is at the centre of power and gender relations, social norms, and expectations linked to the concepts of womanhood and motherhood.

The third section provides a review of the literature on organisation studies and the body, and presents four approaches. The first approach is phenomenological and based on the work of Merleau-Ponty (1962) that understands experience as mediated by the body. The second approach is based on Shilling's 'body work' (1993) and aesthetic labour and examines practices to be done on the body by the body in order to follow organisational requirements in the workplace. The third approach is that which understands the male body as the organisational norm and, in contrast, the female body as 'other' at work. The fourth and final approach is based on the work of Michel Foucault (1975; 1978; 1980) and is based on organisational power and control over the body. I note how this research sits within this fourth approach presented within organisation studies concerned with the body. Finally, this section stresses how the presented approaches primarily focus on the body at work, and how little attention is paid to the body that is at the centre of organisational practices whilst not being at work or employed by the organisation.

The fourth section reviews the literature on organisation studies particularly concerned with the female reproductive body. The section moves on to highlight how most of these works are dedicated to the female fertile or maternal body at work, while little is being researched on how social norms and expectations are reflected in organisational understandings of the female non-reproductive or infertile body. The focus is not only mostly on the body at work, but also in relation to a single organisation, type of organisation, or occupation. Little is known about how different organisations involved with the same type of body construct it so as to legitimise the field they belong to.

Chapter 3 provides a description of the social context that lead to the emergence and development of the field of fertility treatment from 1978 until today. This is a fundamental building block that has seen the flourishing of a field that began with the birth of Louise Brown, the first IVF baby. Specifically, the chapter discusses public ethical concerns with regards to fertility treatment; the 1984 Warnock Committee Report, which called for some form of legal protection of the human embryo and regulations on clinics performing treatment; the 1990 Human Fertilisation and Embryology Act, which instituted the Human Fertilisation Embryology Authority as the national regulator with regards to fertility treatment in the UK; the main civil society organisations and professional associations involved in fertility treatment; and the rise of the Fertility Show. With respect to the thesis' aims, this chapter presents the research context with regards to the events and reactions that shaped the field of fertility treatment and that lead to the creation of the Show, and how the process took place. It further presents how the field obtained legitimacy during its emergence.

Chapter 4 presents the methodology employed in the study. Ontologically and epistemologically informed by social constructionism, the analysis of the field of fertility treatment is carried out following Fairclough's approach to Critical Discourse Analysis (CDA). Specifically, the construction of bodies by organisations is analysed through text analysis, while the construction of relations is examined through discourse practice (Fairclough, 1989/2001; 1992). Finally, in order to understand the reasons for the construction of bodies and relations emerged through text analysis and discourse practice, a social practice level of analysis is carried out.

Chapter 5 presents the research outcomes of the text analysis, and discusses the discourses of the female non-reproductive body employed by organisations at the Fertility Show.

Chapter 6 presents the discourse practice level of analysis, and specifically presents the relations organisations put in place with the bodies emerging in chapter 5. It shows how organisations, depending on the discourse of the body they draw upon, will position themselves in specific relations to the body of the prospective patient.

Chapter 7 presents the social practice level of analysis. Here I analyse documents on the history of reproductive medicine in the UK prior to field emergence, and discuss how each discourse of the body and relation are linked to broader past social discourses on the female reproductive body and on women's role in society.

Based on the evidence provided, **chapter 8** answers each of the research questions in turn. Here I draw together the research outcomes presented in the three empirical chapters,

and discuss them in relation to the literature presented in chapter 2. I then provide reflections on organisations and the female non-reproductive body in light of the research outcomes.

Chapter 9 presents a summary of the thesis and presents its contributions and limitations. Here I also provide suggestions for future research and present some personal reflections and concluding remarks.

1.5. Contributions of the Thesis

This thesis provides five main contributions. First, the thesis contributes to organisation studies concerned with discourse and FCEs by exploring how discourses are generated and employed at FCEs (Hardy and Maguire, 2010).

The second contribution refers to organisation studies and discursive legitimacy. By showing how FCEs discursively maintain legitimacy, this research broadens our understanding of how legitimacy is discursively *maintained* in a particular organisational setting that is spatially and temporally bounded, and thus moves away from studies that have so far primarily focused on more general processes of discursive legitimation (Vaara et al., 2006). Specifically, the thesis contributes to organisation studies concerned with discursive legitimacy by illustrating the discursive strategies employed by organisations at the FCE to maintain field legitimacy.

The thesis also contributes to organisation studies concerned with the study of discourse and FCEs by explicitly positioning text consumers as integral part of the research.

In this regard, the fourth contribution of the study refers to the application of a CDA approach to the study of FCEs, which

specifically requires the researcher to highlight relations of power therein with the explicit intention to question them.

Fifth, this work brings the topic of infertile and non-reproductive bodies into focus in a corpus of literature that has understood the female reproductive body within organisation studies mostly in relation to a state of pregnancy or to motherhood (Gatrell, 2007; 2011; 2013; Brewis and Warren, 2001; Buzzanell and Liu, 2007; Mäkelä, 2005; Haynes, 2008a; 2008b; Cockburn, 2002). By doing so, the research expands organisation scholars' views on the study of the female body in relation to the social expectations it is subjected to.

CHAPTER 2. REVIEW OF THE LITERATURE

2.1. Introduction

This chapter presents the literature review underpinning the thesis and illustrates the gaps that it aims to address. In order to investigate how organisations at a FCE employ discourses of the female non-reproductive body to maintain field legitimacy, four literatures are reviewed: works on organisation studies and legitimacy, organisational fields and FCEs; feminist literature on the female body in relation to reproduction; organisation studies literature focused on the body; and works within organisation studies that particularly analyse the female reproductive body. Respectively, the first literature provides the conceptual toolkit of legitimacy, field, FCE, and discourse through which the research questions will be addressed; the second literature shows how the female body is critically at the centre of reproduction in both a material and social way; and the third and fourth literatures illustrate how scholars in organisation studies have conceptualised the body within the organisational domain, and the female body in relation to reproduction in particular.

The presented literatures are relevant to the thesis' concerns in that they highlight the importance of legitimacy for organisations, organisational fields and FCEs, and the relevance of a discursive approach to investigate legitimacy in these contexts. I particularly stress that little attention has been paid to how discourses are generated and take place at FCEs, despite the acknowledged importance of such organisational phenomena with regards to field configuration, legitimacy and change (Hardy and Maguire, 2010). I also highlight that, when we situate this gap with regards to legitimacy, we know little as to how FCEs can discursively contribute to field legitimacy.

I then proceed to introduce the literature on organisation studies and the body. Here, I present how organisation scholars have approached the body through four main lenses (a phenomenological one, a 'body-work' one, one that positions the male as norm and the female as 'other', and an approach focused on power); how within the works that deal with the female body and organisations, attention is given to the female fertile body which is either pregnant or a mother; and how organisation scholars who have looked at the body have mostly done so by investigating single organisations or a small number of organisations, rather than a field.

It is important to note that the relevance of the focus on organisations and female reproductive bodies is strong in light of current social contexts. The social and political focus on women's bodies in relation to reproduction is in fact at the centre of increased attention: from US president Trump reinstating the Abortion 'Global Gag Rule' act (Terkel and Bassett, 2017) that added to the already problematic US' Targeted Regulation of Abortion Providers (TRAP) laws trying to limit access to safe abortion for American women (Center for Reproductive Rights, 2016) to the arguably acceptable practice of 'objection of conscience' of many Italian doctors who refuse to perform a medical service (abortion) on the basis of personal moral grounds (Lalli, 2016), the social and political regulation of women's bodies spans through countries, cultures, and languages. The non-reproductive body is also strongly tied to cultural norms defining what it means to be a mother, and what it means (socially, privately, and publicly) not to be able to become one. The female body is still a contested locus where rights and practices are constantly being negotiated and reclaimed: it is a centre of power, both disciplinary and

productive (Foucault, 1975), but it is also a locus where norms and practices can be challenged.

The body is also an organisational output and product, a necessary 'ingredient' within certain organisations and organisational fields. This is particularly evident in the case of fertility treatment, where the body is the explicit focus and material outcome of organisational activities. Here, the female body is a necessary 'raw material' onto and with which organisations will work for the material creation of new bodies. The body involved in fertility treatment is both the input and the output of clinical treatment. This peculiar status has over time characterised the field of fertility treatment as ethically sensitive: legal authorities have been publicly called in order to regulate the status of the embryo, a number of civil society organisations have been established to support those undergoing treatment, and various businesses have been set up to provide the infertile with products and services aimed at increasing their chances to conceive. At the same time, society calls for increased reproductive rights and loud public remarks are being made stressing the importance of family planning and contraception (UNFPA, 2016).

Fertility treatment indeed represents an ethically-sensitive field where the body is placed at the very centre of organisational activities: the body is the input, the raw material, it is part of the process as well as its outcome. It is not so in an implicit way, as in the case of the body of the worker, or the consumer; rather, the body is important in its very explicitness and biological existence. As such, the host of organisations involved in the process, be they governmental organisations, NGOs, professional associations or businesses, all find

themselves within a field that needs to be maintained as socially accepted and acceptable, hence legitimate.

Since 2009, the field of fertility treatment in the UK has established an increasingly popular Field-Configuring Event – the Fertility Show. This annual event takes place over two days in London and is aimed at anyone who is trying to conceive. The Show includes as many as 80 exhibiting organisations in the field, that hence have an opportunity to discursively legitimate fertility treatment. To investigate how organisations at the Show employ discourses of the female body to maintain the legitimacy of the field, I employ a conceptual framework that utilises the concepts of legitimacy, organisational field, Field-Configuring Event (FCE) and discourse (2.2). I particularly look at how discourse is employed at the Fertility Show, how it contributes to field legitimacy, and the implications it creates for the female non-reproductive body. Specifically, legitimacy clarifies what it means for an organisation and its activities to be socially accepted and acceptable, and can be pragmatic, moral, and cognitive (Suchman, 1995). Importantly, I distinguish between gaining and maintaining legitimacy, because by the time the Fertility Show was created in 2009, the field of fertility treatment had been active for almost forty years, and thus had already gained legitimacy that needs maintaining.

I then present the concept of field and FCE. Whereas the former helps examine a varied range of organisations that are involved with the same type of body, the latter represents an important locus where organisational fields' 'quest' for legitimacy can be observed in a setting that is spatially and temporally defined and yet influences the field. Finally, discourse represents the core of the analytical approach undertaken in this study, and it is particularly considered in light

of our current knowledge gap as to how discourses are generated and employed at FCEs.

The chapter then presents a number of core academic discussions on the female body in relation to reproduction. Reproduction positions the body, and the female one in particular, at the centre of my analysis (2.3). Understanding how the female body is constructed in relation to its own re-production and to the creation of other bodies teases out the extent to which, within fertility treatment in particular, organisations' understanding of the female body tap into and influence broader social understandings of it.

In the last couple of decades, organisation studies has paid increased attention to the body mostly in relation to the workplace. This chapter further illustrates how the body has been and still is of concern to organisation scholars, and it further highlights how the female body in particular has been acknowledged as a site of organisational power, of both discipline and resistance, and as something that is both an object of organisational social construction and of subjectivity. I identify four main streams or approaches to the study of the body within organisation studies. These are: phenomenological approaches, 'body work' and aesthetics approaches, works based on the identification of a masculine norm which crystallises the feminine as 'other', and works informed by the work of Foucault that focus on issues of control over the body (2.4.). Here, I stress how my study identifies with the fourth stream because of the centrality I give to both discourse and power in my analytical approach.

In section 2.5 I proceed by outlining how scholars in organisation studies have approached the female body particularly with regards to reproduction. Whereas the female

body has been of great focus in organisation studies on the body, I note how the focus on its reproductive potential has mostly been in relation to pregnancy and motherhood for the female employee (Gatrell, 2011; Byron and Roscigno, 2014) or on the sexual aspects of it (Brewis and Linstead, 2000a; 2000b; 2000c). There appears to be a lack of focus on how the female non-reproductive body is understood and conceptualised by organisations that materially work onto, through and thanks to the female body.

By reviewing the above mentioned literatures, this chapter lays the theoretical and conceptual background informing the methodology of the study presented in chapter 4, where I present how data was collected, approached and analysed in order to answer the research questions in relation to the literatures here presented.

2.2. Organisations and Legitimacy

This thesis examines how organisations at a FCE employ discourses of the female body to maintain field legitimacy. Before proceeding with introducing the concept of organisational fields, FCEs and discourse, this section presents the concept of legitimacy and its use within organisation studies and in this thesis. Shocker and Sethi (1974) provide a compelling reflection on the definition of legitimacy in relation to organisations' existence within a social contract in a society. The authors note that

> "Any social institution … operates in a society via a social contract, expressed or implied, whereby its survival and growth are based on: 1) the delivery of some socially desirable ends to society in general, and 2) the distribution of economic, social, or political

> benefits to groups from which it derives its power. In a dynamic society, neither the sources of institutional power nor the needs for its services are permanent. Therefore, *an institution must constantly meet the twin tests of legitimacy and relevance by demonstrating that society requires its services and that the groups benefiting from its rewards have society's approval*." (Shocker and Sethi, 1974: 97, italics added)

The process of obtaining and maintaining legitimacy is thus always on-going, and changes in line with social requirements and criteria. This is important with regards to fertility treatment because what it socially means to be a female non-reproductive body is apt to change in line with broader social changes and perceptions with respect to women's role in society. A recent example of such social changes is the availability of treatment for single mothers, same-sex couples, and women over 40 (HFEA, 2016b), which signals changes in our social understanding of the timings and gender spectrum of motherhood.

Viewed as an organisational resource, legitimacy can be manipulated (Woodward et al., 2001), and can be understood by analysing social values and norms (Dowling and Pfeffer, 1975). In this regard, legitimacy is dependent upon time and place, and fosters the organisation's stability by making it "desirable, proper, or appropriate" in the eyes of its audiences (Suchman, 1995: 574).

The relation between the organisation and its environment or audience is another important aspect of legitimacy. In a key

work on the management of legitimacy, Suchman (1995) provides an extensive reflection on the term by noting that

> "Legitimacy is a perception or assumption in that it represents a reaction of observers to the organization as they see it; thus, legitimacy is possessed objectively, yet created subjectively ... Legitimacy is socially constructed in that it reflects a congruence between the behaviours of the legitimated entity and the shared (or assumed shared) beliefs of some social ground; thus legitimacy is dependent on a collective audience, yet independent of particular observers" (Suchman, 1995: 574)

With regards to this thesis' concerns, we can thus expect congruence between the behaviour of organisations within fertility treatment (which is subjectively created) and the social beliefs on motherhood and the female body (which are objectively possessed). This idea is particularly important because if the organisation (and in this thesis, the organisational field) is to maintain its legitimacy, this congruence needs to be constructed and maintained. Should incongruence take place between the organisation's actions and social expectations, a 'legitimacy test' (Patriotta et al., 2011) or 'legitimacy gap' (Shocker and Sethi, 1974) may occur, and organisational legitimacy may be questioned.

Suchman distinguishes two approaches to legitimacy: a strategic approach and an institutional approach. This separation is still employed within current management studies (see Patriotta et al., 2011). The former views legitimacy as instrumental to organisational goals, and will hence be controlled and used outwardly by managers in a way that is deliberate, and often in opposition to the organisations'

competitors (Suchman, 1995). The institutional perspective is instead focused from the outside in, and acknowledges the importance of cultural environments in determining and constituting institutional life (see DiMaggio and Powell, 1991). Here legitimacy is "a set of constitutive beliefs" that influences the organisation from the outside by seeping into it, rather than being taken from the social environment and used by the organisation as in the strategic perspective (Suchman, 1995: 576).

Within management research, strategic approaches have focused on the role of managerial agency in responding to legitimacy threats and obtaining social support (Oliver, 1991; Pfeffer, 1981; Pfeffer and Salancik, 1978). Within the institutional approach, legitimacy has been defined as "the acceptance of the organization by its environment" and is acknowledged as "vital for organizational survival and success" (Kostova and Zaheer, 1999: 64). Following this perspective, legitimacy is characterised by three factors: a) the features of the organisation's environment; b) the features and actions of the organisation; and c) the "legitimation process" through which the organisation's environment develops its views of the organisation (Kostova and Zaheer, 1999: 66).

Management scholars examining institutional approaches to legitimacy have focused on the analysis of organisations' external pressures to conform to societal expectations (see DiMaggio and Powell, 1991; Meyer and Rowan, 1977) and on how processes of legitimacy are influenced by cultural environments (Friedland and Alford, 1991). Further, scholars have examined legitimacy at both macro and micro levels. On a macro-level, studies have been published on how globalisation impacts legitimacy (Kostova and Zaheer, 1999); on global legitimacy strategies (Scherer et al., 2012); on how

legitimacy is managed within contexts of organisational change (Erkama and Vaara, 2010), as well as at the industry level (Elsbach, 1994). Studies that focus on how legitimacy is obtained and maintained within single organisations and their members have also appeared recently (Drori and Honig, 2013; Brown and Toyoki, 2013). Further, scholars within the institutional approach to legitimacy have stressed the importance played by discourse in creating, maintaining and repairing legitimacy (Elsbach, 1994; Phillips and Malhotra, 2008; Phillips et al., 2011; Vaara et al., 2006).

In identifying types of legitimacy, Suchman takes a "middle course" (1995: 577) between a strategic approach and an institutional one, and acknowledges that choosing between the two is but a matter of perspective. While acknowledging that organisations in the field are at least partly individually able to manipulate their legitimacy to reach their goals, in this thesis I take an institutional approach to legitimacy. This is because I begin my analysis understanding that organisations in the field are socially constructed (see section 4.2.1), thus influenced by their cultural environment. Within this perspective, legitimacy is shaped by what happens outside the organisation, and will 'seep in' and be employed by its members.

Suchman further distinguishes three types of legitimacy: pragmatic, moral, and cognitive. *Pragmatic legitimacy* is linked to "the self-interested calculations of an organization's most immediate audiences" (1995: 579), whereas *moral legitimacy* has to do with 'doing what is right' and is based on normative evaluations of the organisation's activities. Moral legitimacy can be based on *comprehensibility* and *taken-for-grantedness*: when the former is considered, organisations help participants in society to order and understand the social environment,

which is viewed as cognitively chaotic. Moral legitimacy based on taken-for-granted social norms is instead more difficult to challenge and thus provides more favourable ground to legitimise organisational practices. *Cognitive legitimacy* "may involve either affirmative backing for an organization or mere acceptance of the organization as necessary or inevitable based on some taken-for-granted cultural account" (Suchman, 1995: 582). This type of legitimacy can be *consequential*, whereby organisations will be judged by their environment depending on what they accomplish; and it can be *procedural*, whereby organisations will embrace practices, procedures and techniques that are socially accepted.

The three types of legitimacy co-exist. Within the organisational field of fertility treatment, in this thesis I specifically focus on:

a. pragmatic legitimacy, where discourses of the female non-reproductive body may be employed to advance the field's interests. For instance, the female body might be constructed in such a way as to highlight the important role of fertility treatment in society, thereby contributing to maintaining the social need for the field.
b. moral legitimacy, where discourses of the female body may be used by the field to foster comprehensibility with regards to the social role of the female non-reproductive body. Moral legitimacy also may also entail constructions of the female body the organisational field creates on the basis of taken-for-granted social norms on motherhood and womanhood.
c. cognitive legitimacy, which can be consequential if we consider that organisations in the field may be judged on the basis of their ability to help reach a positive treatment

outcome; and which can be procedural if we think that organisations in the field may construct the female body in a way that makes the organisational practices in the field (treatments, tests, donations, counselling) more accepted in light of the established social need for the field's accomplishments (live births).

Table 2. Types of Legitimacy and Fertility Treatment (based on Suchman, 1995).

Pragmatic	**Moral**	**Cognitive**
Instrumental to the field's interests.	a. Comprehensibility of social environment; b. Taken-for-granted social norms.	a. Consequential; b. Procedural.
↓	↓	↓
Constructions of the female body may be employed by the field to foster the social need for fertility treatment.	Constructions of the female body used by the field to foster comprehensibility on the role of the female non-reproductive body in society; Female non-reproductive body constructed by organisations in the field on the basis of social norms on motherhood.	Organisations in the field judged on the basis of their ability to help reach a live birth; Techniques and procedures employed within fertility treatment are considered socially accepted.

2.2.1. Gaining and Maintaining Legitimacy

In this thesis, I distinguish between gaining legitimacy and maintaining legitimacy (see Suchman, 1995; Patriotta et al., 2011). Specifically, I present the organisational field's process of gaining legitimacy in the research context (chapter 3), and from there I focus the analysis on how legitimacy is maintained through organisations' use of discourse at the FCE (chapters 5, 6, and 7).

Suchman lists a number of strategies that can be employed to *gain legitimacy* and *maintain legitimacy.* To *gain legitimacy*, organisations can: a) adapt to the requirements of current audiences; b) choose among different environments the one whose audience will more likely support its practices without requiring significant changes from the organisation; and c) make "efforts to manipulate environmental structure by creating new audiences and new legitimising beliefs" (Suchman, 1995: 587). In this regard, the organisation will "depart substantially from prior practice" and will thus have to "intervene preemptively in the cultural environment in order to develop bases of support specifically tailored to their distinctive needs" (Suchman, 1995: 591).

The process of gaining legitimacy is particularly relevant to fertility treatment because it is a field that emerged with the aim of enabling infertile women to have babies, in contrast to reproductive medicine's initial focus on contraception. I explain this further in chapter 3, where I show how the field gained legitimacy by focusing on the potential future life resulting from fertility treatment. I decided to describe the research context in relation to field emergence because I consider it necessary to know how the organisational field obtained legitimacy before analysing how legitimacy is maintained at the FCE. The obtainment of legitimacy is descriptively presented in chapter

3, where I discuss the emergence and development of fertility treatment in the UK.

With regards to field emergence, Oliver and Montgomery argue that "[s]hared cognitive sense-making" among organisations in a field gains importance during the early stages of field emergence, and helps establish "collective legitimacy" (2008: 1149). It is thus important to briefly look at how organisations collectively created and shared understandings around the female body in relation to fertility treatment when the organisational field was at its early stages. From there, the analysis can be built on a more solid knowledge of how the field got to the strategies of legitimacy maintenance that are employed today at the FCE level. In this thesis, I do not employ the term cognitive sense-making, though discourse plays a similar role in the definition I provide in section 2.2.2.

In order to *maintain legitimacy*, Suchman suggests that organisations need to: 1) perceive change, thus anticipate challenges they might meet through their audiences; 2) protect their accomplishments, either continuously or in an episodic manner; and 3) "[stockpile] goodwill and support" (1995: 595-596). However, these strategies do not take the role of discourse into consideration. The concept of legitimacy maintenance with regards to organisation studies and discourse is still relatively under-theorised (Patriotta et al., 2011), and has mostly been looked at in the context of institutional change (Dunn and Jones, 2010; Thornton and Ocasio, 2008; Townley, 2002); as a quest to conform to dominant logics at the field level (Thornton and Ocasio, 2008; Townley, 2002; Thornton, 2002; Suddaby and Greenwood, 2005); and as controversies between organisations and their stakeholders in response to legitimacy threats (Patriotta et al., 2011). Overall, attention is

mostly paid to how legitimacy is maintained after crises, changes, or threats to legitimacy. In this regard, the FCE represents a peculiar organisational phenomenon to analyse, in that it is not necessarily created in response to field crises or changes. Further, Schüssler et al. (2014) showed how, under certain conditions, FCEs can become "mechanisms for field maintenance" rather than change (2014: 141).

The specific focus of this thesis is on how the Fertility Show, as *a FCE*, *discursively maintains the legitimacy of the field* of fertility treatment. This has to do with the fact that the female reproductive body is at the centre of public debates over what is acceptable and accepted (hence legitimate). This is especially evident in the case of the organisational field of fertility treatment. In this field, discussions of what forms of motherhood are acceptable (Franklin, 2013) abound; but also of what ages are preferable for someone to biologically become a mother (HFEA, 2016b); of the appropriateness of parental laws (HFEA, 2016e); and of what diets and stress-management techniques are better for women who intend to become mothers through treatment (section 5.5.2). Rather than having to respond to particular threats or changes, organisations within this field need to maintain the legitimacy they have gained. Legitimacy allows organisations to offer products and services to the female non-reproductive body, as well as to operate onto it in order to make it reproductive.

I argue that the analysis of a FCE can provide important insights as to how legitimacy maintenance takes place. Scholars have highlighted how FCEs can work towards field maintenance (Schüssler et al., 2014), which necessarily engenders reflections on legitimacy. To date, studies that analyse the role FCEs play

in legitimacy maintenance, particularly through discourse, are missing. I present the related literature in the next section.

2.2.2. Discourse and Legitimacy

Organisation scholars have employed different definitions and assumptions with regards to legitimacy and the tools that can be used to analyse it (Patriotta et al., 2011). As a dynamic concept (Deegan, 2002), legitimacy can be used by organisations to exercise power through consent, which can in turn be obtained through language (Fox and Fox, 2004: xi). With regards to this study, the conditions for legitimacy to be obtained and maintained may change in line with social understandings of the female non-reproductive body. Within society, language use by organisations can foster the obtainment of legitimacy by creating consensus over what it means to be a non-reproductive female body. Language can thus be viewed as a tool to maintain the *congruence* between the organisations' behaviours and societal beliefs argued by Suchman (1995) (section 2.2).

The importance of language when analysing legitimacy has been recognised by scholars interested in organisational change (Vaara et al., 2006; Vaara and Tienar, 2008), in new organisational contexts (Drori and Honig, 2013), in corporate responsibility (Castelló & Lozano, 2011), in cartels in business media coverage (Siltaoja and Vehkaperä, 2010), and in legitimation processes in prisoner identity work (Brown and Toyoki, 2013). Importantly, some scholars have acknowledged how institutions and organisations are socially constructed by discourse, and are principally constituted "through the production of texts, rather than directly through actions" (Phillips et al., 2004: 638).

In this thesis, I am interested in how organisations at a FCE use language to maintain field legitimacy, and particularly examine their use of discourse. The approach to discourse I take is based on Norman Fairlcough's work (1989; 1992; 1995), whose analyses are in turn informed by the work of Michel Foucault. Foucault views discourse as "practices which form the objects of which they speak" (Foucault, 1972: 49) as well as "a system of possibility for knowledge" (Phelan, 1990: 69) which is not fixed or defined by continuity. Instead, discourse appears in often dispersed ways, and this "temporal dispersion…enables it to be repeated, known, forgotten, transformed, utterly erased, and hidden, far from all view, in the dust of books" (Foucault, 1972: 28).

Discourse takes place within historically situated relations, and is constituted by objects of discourse. Foucault provides the example of psychiatric discourse to illustrate how objects of discourse can be examined. These can be recognised by identifying their first emergence, the authorities that define their boundaries, and the ways the discourse is classified and divided (Foucault, 1972: 46). This is however not enough. Foucault argues that it is necessary to focus on the *relations and historical conditions* that made the emergence of certain objects of discourse possible: an object of discourse "does not await in limbo the order that will free it and enable it to become embodied in a visible and prolix objectivity… It exists under the positive conditions of a complex group of relations" (Foucault, 1972: 49). These relations take place between social and economic processes, institutions, patterns and norms, and are not found in the object. Further, they are neither internal nor external to discourse, but rather sit

> "at the limit of discourse: *they offer it objects of which it can speak*… they determine the group of relations that discourse must establish in order to speak of this or that object, in order to deal with them, name them, analyse them, classify them, explain them" (Foucault, 1972: 51, italics added).

If we see the female body as a discourse, we can understand it as existing in a complex group of relations where states, authorities, social actors, and medicine all provide objects of discourse so that a discourse *of* the female body can take place. I view this dynamic as also taking place within organisational contexts and phenomena, including FCEs.

Although it stems from language, discourse differs from grammar in that it is not a consciously learnt method; rather, it creates "the necessary preconditions for the formation of statements", meaning that "the place, function, and character of the 'knowers', authors and audiences of a discourse are also a function of these discursive rules" (Philp 1985: 69). This means that the historical and social contexts of who speaks, how they speak, and who they speak to are all objects of discourse that will contribute to the creation of discourse.

Further, it is important to distinguish discourse from the act of speaking about something. Foucault presents this idea through the repressive hypothesis – the assumption that in the 18th century discourses on sex became taboo and hence repressed. What he found through his genealogical work was, in fact, quite the opposite: discourses on sex multiplied in an attempt to further control it through various institutions. As we can read in the first volume of History of Sexuality,

> "The central issue…is not to determine whether one says yes or no to sex, whether one formulates

> prohibitions or permissions, whether one asserts its importance or denies its effects, or whether one refines the words one uses to designate it; but to account for the fact that it is spoken about, to discover who does the speaking, the positions and viewpoints from which they speak, the institutions which prompt people to speak about it and which store and distribute the things that are said. What is at issue…is the overall 'discursive fact'" (Foucault, 1978: 11)

Thus analysing discourse includes taking into account the conditions surrounding the discourse that is being analysed: not just the 'what', but the 'who', 'why', 'when', and 'where', too. The aim of such analysis is to show how merely talking about an issue does not always or necessarily address it. In the case of sex, Foucault claims that the array of discourses around sex did not, eventually, lead to an increased clarification of sex itself: instead, it led to a "screen-discourse, a dispersion avoidance" (Foucault, 1978: 53) that further clouded the concept of sex rather than elucidating it. Analysing discourse, then, entails taking into account under which conditions something is talked about, and, within this thesis' concerns, why talking about it is considered legitimate or not.

Within organisation studies, and in line with Fairclough's Foucauldian approach to discourse, Phillips et al. (2004) stress how discourses "are always the subject of some degree of struggle... there is always the possibility that actors can influence discourses through the production and dissemination of texts" (Phillips et al., 2004: 637). In the case of the organisational field of fertility treatment and the Fertility Show, this means that organisations can influence discourses of the

female body through their booklets, websites, leaflets, seminars, adverts, and so on. Phillips et al. further highlight a number of points to consider when analysing discourse in relation to institutions and organisations, mainly: 1) that discourse, not actions, is constitutive of institutions through the production, distribution and consumption of texts; 2) organisations are more likely to produce and distribute texts when their legitimacy is involved; 3) organisations that produce texts are more likely to have the authority or power to do so, to be in a legitimate position, or occupy a central position within the field; 4) texts produced by such organisations are more likely to become incorporated into discourse than those produced by peripheral organisations; 5) structured, coherent discourses that "are not highly contested by competing discourses are more likely to produce institutions than discourses that are not" (Phillips et al., 2004: 645).

Discourse, then, is a valuable organisational tool for legitimacy within the field and it is apt for analysis within a FCE setting. In this thesis, I choose to use the term *discourse* in that it can be applied to analyse types and strategies of legitimacy whilst simultaneously allowing for a critical analysis of both organisational texts and broader social dynamics. Further, critical theory's tradition behind the study of discourse is particularly valuable given the empirical setting of this research, which questions gendered social expectations around the female body and reproduction. These have in turn been the focus of much critical work within critical theory, sociology, and feminist studies (see for instance Foucault, 1978; Turner, 2008; Young, 1990).

2.2.3. Organisational Fields and Field-Configuring Events (FCEs)

The study of organisational fields involved with the female body provides several opportunities for organisation scholars interested in this topic: 1) it allows for the investigation of a variety of organisations operating in the same field and that relate to a very specific type of body; 2) analysing a field brings forward underlying conceptions of a body that is the main focus of the activities carried out by all organisations belonging to the field, be they the provision of services or the selling of products; 3) the study of the field of fertility treatment clarifies how organisational activities on the female body are legitimate at the social level, beyond organisational boundaries.

The concept of field is acknowledged as the "central construct" of institutional analysis (Greenwood et al., 2011: 334) importantly also with regards to the investigation of "social systems and processes" (Scott, 2008: 223). Such systems and processes are comprised of fields which can in turn be understood as "local social orders" which are central to the "construction and maintenance of social orders" (Scott, 2008: 224). As such, an organisation field "can be created around an issue as well as a set of products or services" (Scott, 2008: 224).

Organisations within a field "involve themselves with one another in an effort to develop collective understandings regarding matters that are consequential for organizational and field-level activities" (Wooten and Hoffman, 2008: 138). Within fertility treatment, we can expect organisations to share a set of understandings around the female body that will shape or inform organisational activities. This can be expected by virtue of the field's need to intervene in the female body in order to

achieve its primary aim (the birth of a live baby). Institutional theory would name these understandings of the female body as 'logics', or "overarching sets of principles that prescribe 'how to interpret organizational reality, what constitutes appropriate behaviour, and how to succeed'" (Greenwood et al., 2011: 318). Horn defines logics as "the underlying assumptions, deeply held, often unexamined, which form a framework within which reasoning takes place" (Horn, 1983: 1). The field is the typical locus where logics are analysed, as they particularly "encode the criteria of legitimacy by which role identities, strategic behaviors, organizational forms, and relationships between organizations are constructed and sustained" (Suddaby and Greenwood, 2005: 37). Thornton and Ocasio (2008) explain how the concept of logics is more and more employed as a method of analysis rather than just as a theory, and further stress how a number of scholars have instead suggested the adoption of discourse as a method for analysing organisations and institutions (see Phillips and Hardy, 2002; Phillips et al., 2004). Indeed, scholars have noted how "[i]nstitutional fields are held in place by structured, coherent discourses that produce widely shared, taken-for-granted meanings" (Hardy and Maguire, 2010: 1367). Thus, as I presented in section 2.2.2, throughout this thesis I do not employ the term 'logic', but instead adopt the more critically-oriented term discourse.

Further, fields can be emerging or mature, the former being characterised by "unsettled or highly permeably boundaries that allow actors from outside to enter with relative ease" (Greenwood et al., 2011: 336). As new organisations enter the field, new ideas are brought in (Greenwood et al., 2011). An organisation's position within a field is also

important. Organisations are considered central by virtue of their size and/or status, whereas peripheral organisations are seen as "more motivated to deviate from established practices because they are less caught by institutionalized relationships and expectations" (Greenwood et al., 2011: 339). The emerging of a field and the position of organisations within it are of particular importance with regards to fertility treatment in the UK, a field that publicly emerged and became legitimised through the entrance of certain fertility-related organisations from 1978 onwards. By the time the Fertility Show was created in 2009, the field had matured and gained legitimacy. I explain this further in chapter 3.

Part of the current literature on organisational fields and legitimacy originates from social movement scholarship (Goodwin and Jasper, 2015), where scholars have been interested in a variety of matters involving organisational fields and social issues. These include studies on how internally diverse organisational fields help produce movement identity (Levitsky, 2007); how new organisational fields are constructed and evolve, and how networks and the adherence to existing cultural environments are of key importance in such processes (Moody, 2008); how field-developing or -restructuring activities may involve social movement organisations and indirectly channel protests (Bartley, 2007); how mature organisational fields become re-established after radical structural changes are implemented (Reay and Hinings, 2005); and how organisational fields are transformed and change through the practices and the boundaries created by actors in the field (Zietsma and Lawrence, 2010). Desai (2011) notes that little has been done with regards to how legitimacy can be defended within organisational fields, and particularly analyses how

organisations within the same field act when the field's legitimacy is at risk due to scandals or disruptions.

Within this research, a primary concern refers to understanding how organisations within the field of fertility treatment discursively maintain legitimacy through a particular organisational phenomenon, the FCE. Within organisation studies, a field is both legitimised and configured through FCEs. The Fertility Show, understood as a FCE of fertility treatment, represents a peculiar and relevant concept I analyse to understand how organisations within a field discursively maintain legitimacy.

FCEs are considered "both the products and the drivers of field evolution", which means that there is a mutual relation between field evolution and FCEs. This means that, given certain conditions, a field will produce a FCE which will in turn push the field to evolve and be (re)shaped with regards to its "cognitive, normative, and/or social structures" (Lampel and Meyer, 2008: 1028). Studying field legitimacy through an FCE can thus provide us with important insights with regards to how organisational fields are configured, legitimised, and how they may or may not change.

Oliver and Montgomery define a FCE as characterised by

> "(1) a constellation of bonded groups of actors (based on formal union or membership, joint interests, or other common grounds) in which (2) the actors express joint or independent sets of ideas and opinions regarding the issue they are dealing with. The actors express their ideas in a public space (e.g. a conference or the media) in a designated time and place." (Oliver and Montgomery, 2008: 1150)

FCEs can be viewed as "social microcosms" able to "stimulate an unrealized shared vision of a focal technology, market, or industry" (Lampel and Meyer, 2008: 1030). Through FCEs, organisations are brought together in a community of organisations sharing "common meaning systems" (Lampel and Meyer, 2008: 1030), and are spatially and temporally bounded. Furthermore, FCEs involve different aspects in relation to organisations depending on whether the field is emerging or mature. In the former case, the FCE will be centred around normative matters such as identifying practices and developing standards and vocabularies. When, instead, a field moves toward maturity, FCEs are will tend to focus on the expansion and solidification of practices and beliefs (Lampel and Meyer, 2008).

Examining how the field of fertility treatment maintains legitimacy through one of its FCEs allows me to understand 1) *which* discourses of the female body organisations in the field employ *collectively* to maintain the field socially accepted, hence legitimate; 2) *how* organisations use such discourses in this setting to maintain the legitimacy of the field; and 3) *why and how* specific discourses maintain field legitimacy. In order to explore these points, the further section introduces the concept and relevance of discourse in specific relation to FCEs.

2.2.4. Legitimacy, FCEs, and Discourse

Academics have reflected on legitimacy maintenance within institutional theory (Patriotta et al., 2011), as well as on how *discourse* can be employed towards organisational legitimacy (Suchman, 1995; Vaara et al., 2006). From a discursive perspective however, we still know little as to how field maintenance takes place at the FCE (Schüssler et al., 2014); this, in turn, is a question that entails reflecting on

legitimacy. Vaara et al. (2006: 789) note how studies that provide explicit discursive analyses of legitimation are "scarce". Whereas studies on legitimacy and discourse have emerged in the past years (Vaara, 2014; Barros, 2014; Erkama and Vaara, 2010), such a gap is still evident when considering the FCE setting. FCEs have, in fact, mostly been studied in relation to field configuration (McInerney, 2008; Anand and Jones, 2008; Glynn, 2008; Lampel and Meyer, 2008; Garud, 2008) rather than maintenance. We also do not have, to date, studies that take a critical approach to the study of discourse within FCEs.

Studies on organisations and discursive legitimation have focused on theories of justification (Patriotta et al., 2011; Cornelissen and Clarke, 2010) multinational corporations (Vaara and Tienar, 2008), on rhetoric and struggle over legitimacy (Erkama and Vaara, 2010), on ideology in the Eurozone crisis (Vaara, 2014), and on discursive struggles taking place when legitimacy is challenged (Barros, 2014). Within management studies, the role of discourse in processes of legitimation has also been explored with regards to rhetoric (Alvesson, 1993), narrative (Brown, 1998) and metaphors (Cornelissen and Clarke, 2010).

Over a decade ago, Vaara et al. (2006) presented a model of discursive legitimising strategies employed by organisations. Their work is based on that of Van Leeuwen (see Van Leeuwen, 2007), who in turn examined discursive legitimisation through four general categories: authorization, rationalization, moral evaluation, and mythopoesis. His general model, deriving from an unpublished manuscript, has rarely been developed in specific contexts (Vaara et al., 2006). Vaara et al.'s systematic work is the first attempt to produce a model of discursive legitimation within organisation studies.

The authors' model provides discursive strategies for the legitimation of "contemporary organizational phenomena" (2006: 804), and particularly focuses on strategies adopted by journalists and the media, rather than on discourses employed by organisations to legitimise their field. Specifically, there are two reasons that bring me to move away from their model in my analysis. First, the model does not pay adequate attention to text consumers. This is an important aspect to stress because scholars have highlighted how the text consumer has been a missing dimension in organisation studies of discourse, fields, and FCEs in particular (Hardy and Maguire, 2010). While my study is still not including text consumers' direct experience, it nonetheless explicitly moves away from viewing FCEs as loci where organisations are analysed in their mutual interactions, and instead brings to the fore the text consumer as a necessary ingredient for organisations to maintain legitimacy.

Second, within their CDA approach, Vaara et al.'s model excludes a social practice level of analysis to contextualise discursive strategies. This level of analysis aims to socially, historically and/or politically contextualise data. While the authors' choice is understandable given the methodological flexibility of CDA (Van Dijk, 1997; Fairclough, 1989/2001), omitting social practice removes opportunities to question why certain discursive strategies are employed by organisations. Because the aim of my study is precisely to question why certain discourses and discursive strategies maintain legitimacy at the FCE, including a social practice level of analysis is paramount. In this regard, my study adds to the few empirical critical studies on discursive legitimation strategies within organisation studies. I discuss my analytical approach in detail in chapter 4.

I thus hold that the discursive analysis of a peculiar organisational phenomenon such as the FCE provides further room for exploration and expansion with regards to discursive legitimation, legitimacy maintenance, and organisational fields in particular. One way to achieve this is to view FCEs as discursive spaces.

Jacobs et al. define a discursive space as "a site of contestation in which competing interest groups seek to impose their definitions of what the main [problems] are and how they should be addressed" (Jacobs et al., 2004: 442). Further, discursive spaces can provide opportunities to "[relax] taken-for-granted assumptions" and for new things to be said (Fletcher et al., 2009: 84). Viewing FCEs as discursive spaces can generate useful insights with regards to field change, particularly by focusing the analysis of discourse on text production, distribution, and consumption. This is specifically in contrast to organisation studies' broader focus on sets of practices in a field (Hardy and Maguire, 2010; Zietsma and Lawrence, 2010).

FCEs "are important sites for forging new collective beliefs…and developing shared cognitions" (Hardy and Maguire, 2010: 1367) and thus can influence the field for what concerns positions, understandings, and rules. Moreover, whilst we know that FCEs do play a role in field change, we still do not have enough evidence or studies that tell us *how* this can or cannot happen through discourse (Hardy and Maguire, 2010). I also mentioned how authors in organisation studies acknowledge how FCEs are significant tools to understand how a field is not only configured, but importantly legitimised. As I am writing this thesis, a study of how FCEs legitimise an organisational field through discourse appears absent.

In this regard, the most recent and relevant paper to date is Hardy and Maguire's work on FCEs and discourse in relation to field change (2010). The authors stress the knowledge gap as to how FCEs generate discursive spaces; indeed, little work focusing on FCEs and discourse has been published since. In relation to organisational fields, Hardy and Maguire (2010) suggest we view FCEs as discursive spaces that can delay or prevent change. In their study on the Stockholm Convention on DDT, the authors argue that FCEs can create multiple discursive spaces, and that when interpreted as such, FCEs can foster change in the field through domination, interpretation, and translation. A discursive space is where texts are produced, distributed, and consumed (Hajer, 1995), and is characterised by the presence of central and peripheral actors that will take part in the discursive struggle to maintain domination.

So far organisation scholars have used the term discursive space loosely and generally called organisations discursive spaces where different voices might be expressed (Livesey, 2001; Fletcher et al., 2009). Hardy and Maguire (2010) argue that there is a lack of conceptual clarity with regards to discursive spaces within organisation studies, and stress that conceiving FCEs as discursive spaces offers important research opportunities with respect to two distinctive characteristics: 1) FCEs can create multiple discursive spaces rather than single ones; 2) discursive spaces available in FCEs are normally not available in the field. By bringing together organisations that would not normally interact, FCEs provide unique opportunities for "novel or uncommon interactions among field members" (Hardy and Maguire, 2010: 1368). Because of these reasons, the authors call for more research on how FCEs can work as discursive spaces.

In this thesis, I question how FCEs as discursive spaces influence field legitimacy, and particularly focus on legitimacy maintenance. This focus is important to scholars interested in organisational fields and legitimacy, because FCEs are acknowledged to provide discursive room that is usually unavailable in the field and yet has the potential and power to influence it. Further, the discursive strategies organisations attending FCEs might implement toward legitimacy might be different from those emerging in other organisational settings, given the spatial, temporal, and conceptual boundaries of FCEs.

Furthermore, the focus of this thesis is not on processes of legitimation, but on the maintenance of legitimacy. This is due to two reasons: 1) the establishment of a FCE is already a sign that field legitimacy has been at least partly gained, and indeed scholars have noted how FCEs can work towards field maintenance (Schüssler et al., 2014); and 2) because of its dynamic nature and contextuality, once obtained, legitimacy will importantly need to be maintained. Nevertheless, we know little about the maintenance of legitimacy within organisational settings (Suchman, 1995; Patriotta et al., 2011), particularly with how it can be achieved through discourse at FCEs.

My analysis thus aims to contribute to three dimensions within organisation studies: 1) to our knowledge of FCEs, by approaching them as discursive spaces that are unavailable in the field, and by focusing on the discourses they engender; 2) to our knowledge of how legitimacy can be maintained through discourse in an organisational discursive space, which can in turn expand our current knowledge on strategies of discursive legitimation (Vaara et al., 2006); and 3) the study aims to contribute to our knowledge of discourse and FCEs by providing a critical discursive approach to their analysis.

The organisational field and FCE analysed in this thesis are particularly concerned with the female body in relation to reproduction. The approach I take to analyse the field of fertility treatment is a feminist one, due to the importance of the female body for feminist theory and activism. Introducing the feminist literature on reproduction is thus relevant, and further frames the thesis' analytical focus.

2.3. Reproduction and the Female Body: A Feminist Perspective

To understand how organisations use discourses of the body to maintain field legitimacy at the Fertility Show, this thesis particularly focuses on the female body within fertility treatment because of its fundamental role within reproduction. Its biological function is, however, not devoid of gendered social expectations which have over time been challenged. Critical perspectives on women's reproductive lives have traditionally come from feminist scholarship and thought. Within organisation studies, scholars have looked at the female body in relation to reproduction first and foremost as a fertile body that is either pregnant or that has already achieved the status of motherhood. Overall, within organisation studies there is a lack of attention to female non-reproductive bodies. This section introduces feminist critical perspectives on the female reproductive body, before presenting the main works of organisation scholars in relation to the body in general (2.4) and the female body in relation to reproduction in particular (2.5). This section thus highlights existing feminist literature on women's bodies and reproduction, which positions the female body at the centre of social norms and expectations particularly with regards to motherhood.

Currently, the female reproductive body is intensely at the centre of regulation and public attention. The Guttmacher Institute noted that by the end of the first quarter of 2015, only in the US 791 laws on reproductive health and rights were introduced by legislators, the vast majority of which were dedicated to abortion, with 42% of the latter attempting to restrict access to abortion altogether (Guttmacher Institute, 2015). Women's bodies still appear to be under wide and deep scrutiny and regulation by medicine and politics.

Feminists have brought to light issues of reproduction, abortion and contraception for several decades (Firestone, 1970; Rose, 1987; Moore, 2010; Shaw, 2012). We can distinguish two main positions in the literature: one that sees control over reproduction as liberation, and one that sees it as patriarchal oppression of women through medical power. One of the most significant perspectives on reproductive choice is represented by the work of Firestone (1970: 11) who argued for the elimination of sex distinction so that "genital differences between human beings would no longer matter culturally". By identifying the biological family as the cause of the first division of labour, Firestone suggested that the dependency of women on men was due to reproductive differences (1970: 8). She argued that in order to break free from this dependency, a wider use of birth control practices and reproductive technologies would be necessary. However, Haraway notes that despite Firestone's central role in feminist radical debates around reproduction and oppression, her focus was mainly on the power of technology *over* the body, which implied seeing women's bodies as essentially flawed and passive in relation to biology (Haraway, 1991: 10). If we are but victims of our reproductive functions, Haraway argues, then we are preparing the ground for a domination of technology over us (Haraway,

1991). If, following Firestone, we need contraception and reproductive technologies to liberate ourselves, then by leaving technology in charge of our liberation we are ultimately giving up our power, and are therefore either dominated by our biological functions or by the technologies used to dominate our biological functions (Haraway, 1991).

The relation between reproduction and technology is hence at the core of important discussions on the female body. It has been argued that a central issue for feminist scholars must be the increasing power the medical profession assumes in determining who can become a mother, who cannot and on what grounds (Rose, 1987). This is where control over reproduction stops being understood as liberation and starts being conceptualised as potentially oppressive. Medical knowledge becomes the medium and reason behind the use of technology, however invasive and life-changing it will be. When it comes to reproduction, reproductive medicine does offer a technological solution to women's infertility; however, this is achieved by strengthening the "ideology of motherhood" (Rose, 1987: 171; see also Malacrida and Boulton, 2012) and the idea that the status of 'mother' needs to be achieved, regardless of the cost.

The way women's bodies are described in this discourse also contributes to negative images around their bodies, and adds to the already problematic discourses on women's reproductive objectification. When the woman is understood as an object and vessel for future life, often the foetus is subjectified and prioritised (Squier, 1996). For example, Martin (1990) describes images of failure related to menstruation as a 'missed pregnancy'—in terms such as *failure* of the egg to implant, hormonal *deprivation* to the endometrial lining,

disintegration of the endometrium, all of which reflect powerfully the way we conceive women's bodies not just in relation to menstruation but to women's reproductive health as a whole. On the other side of reproduction, Martin found that in medical school physiology texts, words used to describe sperm and sperm creation were all positive (Martin, 1990: 76).

We can therefore understand how women's bodies have often been viewed as essentially controversial, also because throughout their reproductive life they present themselves as non-binary, unruly, and open. This is mostly in contrast to men's bodies, which despite leaking as much as any other body, tend to be portrayed as "self-contained, autonomous and hard" (Longhurst, 2001: 85). Longhurst notes that this is particularly evident in the case of pregnant bodies, which

> "can be seen to occupy a borderline state as they disturb identity, system and order by not respecting borders, positions and rules. …they constantly 'threaten' to split their one self into two or more. … Pregnant women's bodily fluids pose a threat to social control and order. Pregnant women's border ambiguity can become, for others, a threat to their own borders." (Longhurst, 2001: 84)

Pregnancy is not the only event in a woman's life and body that is widely socially constructed as borderline and as of threat to the social order. Hormonal processes, too, seem to foster disease categories and suggest the need to contain features that are, by 'nature', not meant to be contained. This is important also with regards to power concerns: for instance, portraying Pre-Menstrual Syndrome (PMS) as a disease category that is gendered has been argued to "reinforce and reproduce power relationships of gender" where "the female

body is positioned at the site of dysfuction" (Swann, 1997: 180). Discourses on the female dysfunctional body based on the cultural construction of female hormones have in the last decades occupied a significant position in the way gender and behaviour have been understood and studied (Swann, 1997). Besides PMS, this can be noted with regards to the menopausal body, seen as a diseased body that, because of its oestrogen-deficiency, should be treated by hormone replacement therapy (HRT) (Hunter and O'Dea, 1997). From their study on women's experiences of menopause, Hunter and O'Dea reflect that

> "During the reproductive years, the causes of women's distress have been located in their reproductive bodies. After the menopause we might expect to become free from such biological attributions in view of the change in reproductive status. It is ironic that at the menopause 'lack of hormones' becomes the problem and another explanation for female problems." (Hunter and O'Dea, 1997: 217)

Such questionable location of women's 'distress' is partly due to the increasing moral role taken by modern medicine, which has a considerably deeper impact on women than men particularly with regards to reproductive and sexual health (Turner, 2008: 187). Viewing the body as "a hierarchically organized bureaucratic system of control" (Martin, 1990: 74) has further important implications as to how the body is conceived in terms of functional/dysfunctional; ultimately, the message delivered is that, for instance, "women are, in some sinister sense, out of control when they menstruate instead of getting pregnant" (Martin, 1990: 75). Women's bodies, then, are infused with negative conceptions around menstruation

(failure to achieve pregnancy), menopause (ovaries become 'unresponsive'), and the lack of reproduction more broadly.

The issue becomes more intricate when considering infertility and its conceptualisation as an illness. In most cases, infertility cannot be defined as a life threatening disease, and there is no specific scientific meter to calculate exactly when someone should stop trying to conceive without treatment and becomes medically infertile (Pfeffer, 1987). However, infertility allows for medicine to exercise its moral role by giving "people a 'normal marriage and family life… Marriage can be 'saved' by the presence of children" (Zipper and Sevenhuijsen, 1987: 131).

Health and organisations appear clearly intertwined in fertility treatment. The normalisation process that has led to the increase in treatments (Moore, 1999) makes room for further reflections on issues around women's bodies and conceptions of womanhood. The exclusion of the body (and in particular, women's bodies) from social and political discussions has been seen as linked to the historical exclusion of women as a subject in political theory and philosophy. Because of this exclusion, women's bodies in particular are still regulated, treated and medicated passively (Rawlinson, 2001). This absence of "active" women's bodies is not as theoretical as it may seem. Bacchi and Beasley (2002: 335) argue that women discussing reproductive autonomy are often (mis)understood as "a maternal space to be filled". This is problematic for two reasons: women are seen as passive agents when it comes to their own reproductive choices; and the insistence on procreation in light of infertility might justify "forms of intervention and control that generally would be frowned upon"

(Bacchi and Beasley, 2002: 335), such as physically and emotionally invasive practices and tests.

Feminist scholars have been involved with issues around reproduction and the female body mostly in critical terms, and have highlighted the heaviness and dangers of some of the most widespread social expectations in relation to women's bodies: 1) that women are defined in relation to their reproductive potential, and hence understood as either mothers or mothers-to-be; 2) that reproduction needs to happen for the woman to be functional and normal; and 3) and that within reproductive choice and medicine, women are still mostly treated passively.

The next section introduces how scholars within organisation studies have been involved with such concerns. This thesis further develops how women's bodies are understood when reproduction does not take place. It examines how constructions of the female body are used by organisations to legitimise their interventions in such a body, as well as the existence of an entire organisation field aimed at making the female body reproductive. The next section provides a review of the current organisation studies' literature on the body, its developments and approaches, and anticipates the more specific review of organisation studies' works on the female reproductive body (2.5).

2.4 The Body in Organisation Studies: Origins, Developments, and Approaches

In this section, I present the sociological origins and developments of analyses of the body within organisation studies, and identify four main approaches to the study of the body within organisation studies. I review this literature to provide an outline of the academic interest in the body within

organisation studies to date, as well as of the different ways the body has been analysed in this specific corpus of works.

Within sociology, the body has been looked in a variety of ways, be they theoretical, analytical, or historical (Hancock et al., 2000: 4). The aim of this section is to give an overview of how the body has come to be a focus of sociological inquiry, and to present the main sociological works in what has been called 'the sociology of the body' (Shilling, 1993) that was later absorbed by organisation scholars. Historically, the body has prominently been studied by other disciplines, such as biology, anthropology and psychoanalysis (Frank, 1991). Sociology has in fact only relatively recently 'caught up' and abandoned its disembodied approach to the study of society: this was mostly due to a widespread philosophical acceptance of the Cartesian dualistic model of mind/body division, where human beings were considered social only in relation to their rationality (Shilling, 1993: 9).

There has been an acknowledged absence of the body in organisations – organisations were, just as sociology was initially, 'disembodied', until the critique of modern tradition and separation of mind/body became widespread among scholars. The focus on the body in relation to organisations came from "a managerialist concern with problems of efficiency and worker motivation under the demands of industrial capitalism" (Hancock and Tyler, 2000: 87). Within organisation studies, Taylor's scientific management; Weber's dystopia of bureaucratic administration in the workplace; the Human Relations school and organisational psychology; Foucauldian studies focused on the control of employees' bodies at work; and corporate culturism have been some of the most relevant approaches through which scholars started paying attention to the body in their analyses.

Taylor's system of 'scientific management' (1911) postulated modes of organisation deriving from the natural sciences, which in turn reflected the importance given to mind over body, to culture over nature, to man over woman (Dale, 2001). Here, "the human body was envisaged as little more than an instrument of labour, a source of effort and skill" (Hancock and Tyler, 2000: 87). Taylor's principles of scientific management dominated processes of production and significantly changed the extent to which the worker was subject to fixed and established controls by the employer. Here, the working body becomes the object of inquiry "in order that the human body…could become the object of exacting control" (Hancock and Tyler, 2000). By doing so, Taylor favoured the conception of the body (and the worker) as object and consequently the disregard of the body as subjectivity (Dale, 2001). The worker's body was initially only seen as a machine to be controlled, a separated object of labour, until the 1930s when employers' attention shifted from controlling their workers' bodies to winning their 'minds' (Hancock and Tyler, 2000).

The work of Weber further shed light on how the development of the modern form of the organisation progressed at the same pace as that of the spread of bureaucratic administration (Dale, 2001). Weber was concerned with workers becoming but cogs in the modern factory machine, and stressed that disciplined and rationalised bodies were key to a successful economy. In his words, the worker "is attuned to a new rhythm through the functional specialization of muscles and through the creation of an optimal economy of physical effort" (Weber, 1968[1921]: 1156). The preoccupation with disciplined bodies in the workplace was also the focus of organisation studies coming from a Marxist tradition, where

workers' subjectivities were seen as fractured and alienated under capitalist modes of production (Dale, 2001: 193). Braverman's labour process theory (1974) further paid attention to control over the body of the worker, and analysed how workers' bodies and their movements were mechanised, deskilled, and standardised in the workplace in order to increase mass productivity.

A significant shift in the control of workers took place in the 1930s, when, based on the modern acceptance of the hierarchy of mind over body, organisational focus moved from workers' bodies to workers' minds. The Human Relations school (see Mayo, 1933) particularly is linked to the rise of organisational psychology. The psychological wellbeing of workers became increasingly prominent thanks to works like Maslow's hierarchy of needs (1958) and Herzberg's work on workers' motivation through 'job enhancement' (1968).

It is particularly thanks to postmodern thinkers that the body made, perhaps more explicitly than before, its way back into organisation studies. Michel Foucault's work on disciplinary power (1978) and bio-power (Martin et al., 1988) specifically informed a number of studies on organisational control over workers through Human Resource Management (Townley, 1993), technology (Sewell and Wilkinson, 1992; Steingard and Fitzgibbons, 1993), and the creation of 'total institutions' around workers' bodies as well as the possibility to resist them (Burrell, 1984).

Another stream of organisation studies that centres on the body is that of corporate culturism. Here, workers' body image, feelings and 'hearts' (Hassard et al., 2000: 6) came to be the target of organisational control through was Peters and Waterman call "hoopla, celebration and verve" in the workplace

so as to maintain an atmosphere of corporate excellence (1982: 263). Van Maanen's work on Disney's 'smile factory' is also significant: workers are expected to behave and show emotions that are concomitant with organisational values and ethos, and emotional management becomes part of the job (1991).

Dale argues that the "objectified disembodiment" within organisation studies has led to analyses aimed at conceiving "a 'best fit' between the individual and an aspect of their job or the organisation" (2001: 185). As a result, most organisation theories up to the early 2000s fail to focus on "the individuals who constitute (or are constituted by) the organisations of which they write", and consequently "[a]ttention is only directed towards the identity or the body of the individual organisational members in order to manipulate these to achieve a control and normalisation of them" (2001: 182). Whereas the first point she presents has changed significantly in the last decade within organisation studies, there still is some truth in the last quoted sentence. Much focus of organisation analyses is indeed centred around organisational members and/or individuals directly involved with the organisation, for instance by being employed or contracted by it.

The approaches presented so far have been criticised for not paying adequate attention to gender and subjectivity. This is particularly true for Weber, Braverman, and Foucault. Critiques have come from feminist scholars (see Diamond and Quinby, 1988), but also from scholars within organisation studies (see Knights and Willmott, 1990; Dale, 2001).

Attention to the body in organisations was particularly strong towards the late 1990s and early 2000s. However, a lot has changed in the last sixteen years. Other approaches which focus on the body as a starting point of analysis have also been

developed within organisation studies. Specifically, these are here grouped as: phenomenological approaches to the body, studies focused on what Shilling called 'body work' (1993) and aesthetic labour, approaches focused on highlighting the male norm in the workplace in relation to the feminine 'other', and studies on power informed by Foucault. This division is not definitive, and by no means are these approaches to be read as mutually exclusive: on the contrary, many scholars in organisation studies have examined the body in a variety of contexts and through an array of different analytical lenses. As I will discuss later in the chapter, all these approaches tend however to maintain their focus within the organisational setting and in specific relation to the worker's body.

By presenting these four approaches, I aim to show that organisation scholars have so far not focused on the body and legitimacy, or on the social acceptability of the organisation based on how they construct the body. Rather, scholars have largely focused on organisational control over the body, mostly at work and within single occupations or organisations. Thus, what I ask in this thesis is: can discourses of the body be used to legitimise not just a single organisation's existence, but a whole organisational field? That is, can the body be constructed by a multitude of organisations involved with the same type of body, and used to maintain legitimacy? And if so, how? As previously mentioned, I particularly question how discourses of the *female non-reproductive body* are employed to maintain the field's legitimacy at one of the field's FCEs. I explore this topic with respect to the existing literature in section 2.5.

As mentioned above, the current literature on body and organisations can be divided into four streams: phenomenological approaches, approaches informed by

Shilling's concept of 'body work' (1993) and aesthetic labour, perspectives that highlight the social and organisational construction of a male norm and a feminine 'other', and approaches informed by the work of Michel Foucault and focused on power and control.

Deriving mostly from Merleau-Ponty's *Phenomenology of Perception* (1968), phenomenological approaches to the study of the body and organisations focus on perception and bodily experience in contrast to the rational and disembodied perspective traditionally found in studies on the body. In an attempt to challenge the hierarchy of mind over body, experiences are understood as mediated *by* the body (Casey, 2000). Some authors use a combination of different philosophical works to challenge dualistic thinking and to favour a merging of concepts into more encompassing theoretical frameworks able to account for workers' embodied experience (see for instance Dale, 2001, who proposes the use of Foucault, Merlau-Ponty, Young, and Irigaray).

Works within organisation studies include the very physical and sensorial aspects of work, such as Gatta's account of the physical coordination required from waiting staff in service work (2009), and Sennet's work on the importance of the sense of touch in relation to the craftsman trade (2008). Hockey and Allen-Collinson's work further brings phenomenology to the fore by focusing on how "to address the sensorium at work" (2009: 220) and the sensory practices that are required in daily working practices.

The second approach is informed by the concept of aesthetic labour and 'body work'. Aesthetics has been defined by Hansen et al. as "*sensory knowledge and felt meaning* of objects and experiences" (2007: 545). Originally, the concepts

of aesthetic labour and body work derive from the sociological work of Goffman (1963; 1968; 1969) and Shilling (1993). Goffman argued that it is through our bodies that we intervene in society. His interest was particularly in the body "as a component of *action*" (Shilling, 1993: 71) rather than control. Goffman's interest has been on the importance of the body in public and private social interactions (1963), in our handling of stigma through our bodies (1968), and on the 'presentation of self' (1969) through clothes, make up, and aesthetics in relation to our expression of social position. The body is understood as a "material property of individuals" (Shilling, 1993: 82), over which they have control and through which they exercise agency. Within this perspective, the body becomes part of the social world in a very direct and aesthetic way: the way we present ourselves and behave through our bodies are closely linked to what we can and cannot do. At the same time, we also need to work on our bodies to be able to function and participate in society – what Shilling calls 'body work' (1993; 2005). In the author's words

> "Body work is rarely called work, but in cleaning our teeth, washing our bodies, cutting our nails, making-up, or shaving our legs or faces, we are all working on our bodies. Sociologists have talked of the work that carers do for others and, implicitly at least, the bodies of others, but have yet to look at the work the cared for do on their own bodies." (1993: 118)

In organisation studies, scholars have focused on the aesthetic of the body and how work done aesthetically on the body is often necessary and used to maintain what Tyler and Abbott call the 'organizational body' (1998) – that is, our status of employee in that organisation. The body is considered part

of the organisation also when not at work (see for instance weight management and aesthetic labour for air hostesses in Tyler and Hancock, 2001), which hints at an organisational reach over the employees' bodies that goes beyond traditional organisational boundaries.

Within this approach, an individual's work on the body is reflective of the aesthetic code of the organisation (Harding, 2002). This is relevant for leaders and managers (Harding, 2002; Hansen et al., 2007), but also for service workers (Hancock and Tyler, 2000), for fashion sales workers (Leslie, 2002), and in general for the importance of aesthetic labour in the workplace (Witz, Warhurst and Nickson, 2003). Further stress on physical appearance is evident in Warhurst and Nickson's concept of 'lookism' (2009), where organisations select employees depending on their physical attractiveness. Other authors focus on workers' emotional management in order to become a 'successful corporate character' (Hatcher, 2008). Brunner and Dever (2014) further explore how the increased requirement of sexualised body work by organisations requires employees to 'self-manage' and creates flexible boundaries between being on and off work. The work of Carol Wolkowitz (2002; 2006; 2011) is also relevant to this approach. She particularly focuses on what she calls the body/work nexus (2006) which includes the work undertaken by the body when involved in the production of goods and services – such as the body work required, for instance, in the construction of buildings or in an assembly line.

The third approach is that which maintains the social construction of the masculine as a norm and positions the feminine as 'other' in the workplace. Because of the widespread acknowledgement of the importance of feminism in the

corporeal turn taken by sociology and, later, by organisation studies, most of the work in organisation studies and the body is informed by feminist scholarship. There is, however, a number of works that focus on how the female and the female body are constituted as different, as 'other', by virtue of not being male. Feminist scholars and thinkers have been acknowledged for bringing to the fore issues of power, sex, and inequality within patriarchal societies. Moreover, they are recognised as essential contributors to our current awareness and knowledge regarding the body in its sexed, sexual, and socio-political terms within both the sociology of the body (see Turner, 1991; Featherstone et al., 1991; Hassard et al., 2000; Hancock et al., 2000) and organisation studies that deal with embodiment (see Jeanes et al., 2011). Women's bodies are seen as a site of power, and the means through which men obtain control over women's bodies and choices. The stream of organisation studies I present in the next section is particularly informed by feminist theory (Butler, 1990; Grosz, 1994; Irigaray, 1985; Young, 1990), in that authors openly discuss issues of gender, inequalities, and sexed bodies. This is not to say that the authors I have included in the other streams are not informed by feminist scholarship (in fact, most of scholars in organisation studies that analyse the body embrace it), but that, within this stream, the feminist imprint is particularly stark and it is a strong initial point of analysis.

These works show how organisation are gendered in a way that constructs the male as the neutral norm, associated with the mind in the mind/body dichotomy and as that which is controlled, rational, contained, and capable of authority. On the other hand, the female is constructed as the 'other' - that which disrupts, transgresses, and poses a danger to organisational practices and boundaries. There is also considerable work in

relation to the masculine norm, including many studies on the construction of male bodies and masculinity.

The work of Acker (1990), despite being almost thirty years old, is still acknowledged as being particularly important. She argues that organisations are gendered in that they are based on a strong distinction between male and female where the feminine 'other' is used as 'grounds for control' (1990: 152). Further, organisational structure itself is not gender-neutral but based upon the assumption that the abstract ideas of job, work relations and hierarchies rest upon a "disembodied and universal worker" that "is actually a man" (Acker, 1990: 139).

Cockburn (1991) unveiled how gender plays out in relation to women's bodies and sexuality in her study of men's reaction to positive action for sex equality at work. Here, she noticed how displays of emotion were understood as implying a lack of control, which led to women being seen as incapable of exercising authority. She also noticed how women's sexuality is always present in the workplace, and because of this they are seen as distracting. The female body emerges as being constructed as inherently sexual, disruptive, and dangerous particularly when pregnant (Longhurst, 2001) and transgressing organisational norms through their sexuality, even if only perceived (Hearn et al., 1989).

Another area of focus has been male bodies and the construction of masculinity at work (Collinson and Hearn, 1996; Collinson, 1992; Connell, 1995; McDowell, 1997; Monaghan, 2002; Roper, 1994; 1996; Hall et al., 2007), often in relation to femininity (see for instance McDowell, 1997) and to how discourses on and the construction of the male body perpetuate conditions of men's dominance in organisational settings and through managerial practices (Kerfoot and Knights, 1993; 1996; see also Knights, 2014). Sinclair (2005) argues that

whenever the body within organisations is rendered invisible, then the mind (which is male) takes priority, and men are seen as having stronger intellect and minds in relation to women.

Further, there are a number of studies specifically focused on leadership and gendered bodies. These examine how the body of managers, particularly male ones, are constructed and the effect they have in the workplace. Sinclair (2005; 2011) argues that mind and body are not separable, and focuses much of her work on leadership and on how gender influences bodily practices. Works like the ones published by Hansen et al. (2007) examine leadership and corporeality by bringing a focus on the senses into their analyses through the concept of aesthetics. Other studies maintain that the body is a means through which culture is enacted, but keep a specific focus on the managerial body (Kenny and Bell, 2011).

The fourth and final approach I identify is informed by the work of Michel Foucault, and is concerned with how organisations control workers' bodies. The corpus of work I present in this section is based on concepts of power, control, and performativity. The authors I mention mainly base their analyses on issues of control, surveillance, and resistance. Most are informed by the work of Foucault, although in some cases (see Ball, 2005) other schools of thought are considered. Scholars informed by Foucault share the view that power can act as or through discourse; that the body can be a site of resistance to power; that bodies can be disciplined and controlled in the workplace; and that bodies are constructed in relation to particular norms through language (see Foucault, 1972; 1975; 1978; 1980).

Authors like Knights (2014) and Brewis (2001, Brewis and Linstead, 2000a; 2000b; 2000c) use Foucault's work when

arguing for the importance of power/knowledge and the creation of 'truths' through discourses, for the deconstruction (or the dissolving, as in Knights 2014) of gender binaries, and for the performativity of gender in the workplace.

Barbara Townley (1993) argues that human resource management can be understood as a discourse that renders the individual more knowable and hence controllable. By doing this, she stresses how issues of discipline and control in the workplace relate to the power/knowledge nexus theorised by Foucault, and adopts the view of discourse as a site of struggle. As previously mentioned, in her work on gendered organisations, Acker (1990) notices how the distinction between male and female in organisations reinforces control in the workplace.

Building on Acker's work, Byron and Roscigno (2014) analyse legal cases of pregnancy discrimination in organisations and notice how the hegemonic and patriarchal legitimation of discrimination takes place through "legitimating discourses and framing of social realities and distinctions therein" (2014: 441). Their relational framework entails that "it is the interplay of more and less powerful actors, but also structure (i.e. law and bureaucratic policy) and cultural discourses that contribute to inequality and power differentials, including those surrounding pregnancy and employment" (Byron and Roscigno, 2014: 441). Through their analysis of closed cases, they notice how pregnant women were fired and replaced with non-pregnant women and stress the importance of paying attention to differences among women (2014: 445). They further show how the discrimination carried out by employers does not exclusively reside within organisational practices, but is also legitimised "in larger, culturally resonant discursive strategies imbued with gendered proscriptions and that elevate institutional

meritocracy and business profit rationales" (Byron and Roscigno, 2014: 456). I further discuss pregnancy in the workplace in section 2.5.

Other scholars examine how the body is controlled and deprived of agency. Hope (2011) argues that in Western societies the body is controlled not only by the state and by companies, but also through religious grand-narratives that take agency away from the body itself. Some acknowledge the dangers deriving from organisational surveillance and seek avenues for embodied resistance: Ball (2005) explores how the body as lived experience intersects with power and is seen as a potential site for resistance in relation to surveillance. She acknowledges the theoretical opportunities provided by Grosz (1994) and Haraway (1991) in thinking about resistance to body surveillance in the workplace, and focuses on how such practice can be politicised and resisted.

Tretheway (1999) uses a Foucauldian feminist lens to analyse how women's professional identities are produced by gendered and organisational discourses that are inscribed onto their bodies. Some of Brewis' work (2001) is informed by Foucault's regulation of sexuality (see Foucault, 1978) to illustrate how women's sexuality is regulated in the workplace. Brewis and Linstead (2000b) apply a Foucauldian approach to knowledge and discourse to examine how sex workers manage the permeable boundaries between work and non-work, and to discuss the discursive complexity of the industry and of the profession of sex workers (2000c). In their book *Sex, Work, and Sex Work*, Brewis and Linstead (2000a) further present how sex and sex work can be both organising and disorganising factors in society. The authors discuss how work and the workplace are sexually organised (by for instance looking at issues of sexual harassment in the workplace, and the construction of the

abject), and how sexuality, nowadays commercially commodified, is in turn organised in a context that sees the body as a commodity.

Burrell (1984) analysed how sexuality has been controlled and resisted in organisational life. In doing so, he uses Foucault's concept of resistance and provides a genealogical account of the desexualisation of organisations, and notices how we have "ignored what novelists and playwrights and organizational members know only too well – that sexuality is a major driving force behind human endeavour" (1984: 115).

In this thesis, I align my approach to the body and organisations to this last approach I presented. I particularly endorse the view that discourse 1) can be constitutive of relations of power, of gender, and of sexuality in organisational contexts; and 2) can legitimise organisational practices (as in Byron and Roscigno, 2014).

However, the four streams I presented mostly focus either on the body at work or on the body within the organisation. There seems to be a missing dimension whereby the body can be involved with organisations by being the very product or centre of organisational practices. Here, the organisation's involvement with the body is more essential and direct.

The female body and reproduction have nonetheless been explored through more central and macro lenses, most notably by Brewis and Linstead (2000a; 2000b; 2000c) and Brewis and Warren (2001). Brewis and Warren's work (2001) particularly shows us that whereas organisation scholars have mostly focused on the *productive* body, valuable reflections can engender from shifting the focus to the *reproductive* body in relation to organisations. In this regard, in this thesis, it is the role of the organisational field that is shifting: where it usually

requires the body to produce, the organisational field at the centre of my analysis aims at a *reproducing body* as the outcome of its activities.

The next section further narrows the theoretical focus, and introduces organisation scholars' involvement with women's bodies in specific relation to reproduction. This literature is significant because it shows how scholars have indeed focused on the topic of reproduction, particularly in the workplace. It further allows me to identify the lack of organisation studies works on female non-reproductive bodies and organisations, thereby stressing the silence on infertile bodies within the discipline.

2.5. The Female Reproductive Body within Organisation Studies

Scholars in organisation studies have been involved with issues of female bodies and reproduction with a strong focus on the employed pregnant body and the maternal body (see Gatrell, 2011). These works are particularly important to organisation scholars interested in reproduction, because they highlight how organisations are entities where social expectations and norms of motherhood are constructed, reproduced or maintained.

The main body of work presents investigations on pregnancy, motherhood, and discrimination against pregnant women in the workplace (Mäkelä, 2005; Malenfant, 2009; Lyness et al., 1999; Halpert et al., 1993; Warren and Brewis, 2004; Brewis and Warren, 2001; Cockburn, 2002; Corse, 1990; Cunningham and Macan, 2007). Gatrell (2013) explores the concept of 'maternal body work' and attests to the low engagement of organisation scholars with feminist perspectives on motherhood. She highlights how in her study the majority of

mothers interviewed "felt marginalized and undervalued" (2013: 621) and highlights two ways in which women perform maternal body work in the workplace. The first one is concerned with what is considered "good mothering according to health narratives" and the second relates to "maternal obligations to conform to embodied norms within professional and managerial workplaces" (2013: 639). The woman is hence expected to follow social expectations on motherhood while remaining a good professional worker. Previously, the author investigated the practice of breastfeeding at work and the conflicts that the relation of the two engenders (Gatrell, 2007). She highlighted the taboo status of breastfeeding in the workplace and noted "the conflict between health advice and organisational practice" (2007: 393). Her study brought to the fore women's bodies as leaking loci that should be contained, as well as loci of social fears related to sensual pleasures.

Malenfant (2009) shows how health-related risks in the workplace with regards to a woman's pregnant status are used by employers "to maintain the status quo" (2009: 205), while Halpert et al. (1993) stress not only the higher incidence of discrimination of pregnant women in relation to non-pregnant women in the workplace, but further highlight how men tend to discriminate against pregnant women more often than other women. Lyness et al. (1999) examined organisational and individual factors that affect women's maternity leave and return to work and noted that women whose perception of the workplace toward work-life balance was more supportive were "more committed to the organisation and planned to return more quickly after childbirth" (1999: 485). Haynes (2008a; 2008b) investigated women's experience and sense making of motherhood and employment as well as processes of embodiment of pregnant women and new mothers in the

workplace. Buzzanell and Liu (2007) note how maternity leave can be understood as a process of conflict management between the employer and the woman, whereas Cunningham and Macan (2007) examine how a woman's pregnancy influences an organisation's hiring decision and note how pregnant women with the same qualifications and interview performance tend to receive lower interview ratings and are hence less likely to be hired than non-pregnant women.

Brewis and Warren (2001) analyse productive labour and reproductive labour as organising projects and focus on reproduction as a way to organise beyond the work organisation. They particularly focus on pregnancy and argue that organising is a broader social process that happens outside and beyond the work organisation as a setting. In a later study, the authors interviewed pregnant women to understand how they experience their bodies and define pregnancy as a specific 'body episode' defined by Western culture as one where women have incomplete control over their bodies. This pushes pregnant women to construct more positive understandings of their bodies, and to enjoy pregnancy as a 'body episode' defined by a different degree of control over one's body (Warren and Brewis, 2004).

Outside organisation studies, other works have focused on legal perspectives on the above mentioned discrimination taking place with regards to pregnant women and new mothers (James, 2007; Edwards, 1996); on feminist accounts of women's perception and anticipation of stigma in the workplace (Fox and Quinn, 2015); and on the health of the pregnant woman in relation to her employment status (Baker et al., 1999).

However, by looking at how the female body is constructed by an organisational field when not reproducing, this thesis addresses two gaps found in the reviewed literatures:

1) a lack of studies on *organisational fields and the female body*, and gender issues more broadly. Analysing organisational fields is significant because, by the very definition of organisational field (see section 2.2.3.), we can expect a group of organisations dealing with and collectively constructing the same type of body. Because these organisations are a multitude rather than a single or small group of organisations, the discourses they employ may influence broader understandings of that body than single organisations. This brings us outside the single organisation's construction of the female body, while still maintaining an organisational focus.

2) There appears to be an unfilled gap of organisation studies examining the female non-reproductive, or infertile, body. Organisation scholars informed by feminist perspectives and interested in women and reproduction have so far mostly focused on the fertile female body. Little if no attention has been given to the role organisations play when the female body is not reproducing. Social expectations are strong with regards to pregnant bodies, but that might as well be related to the broader social expectation that women are but "maternal spaces to be filled" (Bacchi and Beasley, 2002: 335), regardless of their place in society or academic disciplines. Women who do not reproduce, either voluntarily or not, are subject to social and gendered expectations related to motherhood just as women who are mothers are.

By focusing the analysis on infertile bodies, I attempt to bring some balance to our discussions on women and reproduction. Fertility treatment is a field that uses discourses

of a body that is usually invisible, and in the case of this research I will be investigating how discourses of this body can be employed to maintain field legitimacy. This contributes to bringing balance to our discussions, particularly because fertility treatment is a field that *explicitly* brings attention to the female non-reproductive body: indeed, the field would not exist without it, and explicitly needs this 'type' of body to carry out practices and to measure its achievements. Studies that focus on organisations and the infertile body are currently lacking in our discussions of organisations that deal with the body, gender, or even discourse.

Because they deal with social norms and expectations of motherhood just as much as they would if they dealt with a maternal body, organisations in the field need to gain and maintain legitimacy to be socially acceptable and accepted. This thesis explores how discourses of the female non-reproductive body are employed by organisations attending one of the field of fertility treatment's FCE. By doing so, I move away from the single organisation as a locus where the female body is constructed, and instead focus on the broader organisational field.

2.6. Conclusion

In this chapter, I reviewed a number of key literatures related to the thesis' aims. Specifically, I presented the literature on organisations and legitimacy (2.2.), distinguished between pragmatic, moral, and cognitive legitimacy; and discussed how legitimacy can be gained and maintained (2.2.1). I then presented how numerous scholars have acknowledged the importance of the study of discourse within organisation studies, its relevance to the analysis of legitimacy,

and discussed the Foucauldian approach to discourse I take in this thesis (2.2.2).

I further introduced organisational fields and FCEs, and how I employ them in this thesis (2.2.3). I then proceeded to present FCEs and the opportunities they offer with regards to the analysis of legitimacy. I particularly view them as discursive spaces where discourse might be employed in particular ways given the peculiar nature of FCEs. I highlighted how, whereas we do know that FCEs play a role in field legitimacy, the extent to which they do so through discourse is relatively still unexplored (2.2.4). At the end of the section I present my threefold contribution within organisation studies: a) approaching FCEs as discursive spaces allows me to extend our knowledge as to how FCEs influence field legitimacy; b) the analysis of a discursive space can provide important knowledge as to how legitimacy can be maintained through discourse; and c) an approach to the analysis of discourse and FCEs that is critical is missing, and yet offers valuable insights as to how relations of power influence a field's efforts to maintain legitimacy.

The chapter continued with a discussion of the central issues of reproduction and the female body, and their long-standing relevance within feminist literature (2.3). Here, I highlighted how women appear to be defined in relation to their reproductive potential; how women are considered 'normal' when reproducing; and how women are still treated passively by medicine in relation to reproductive choice. I then proceeded to show how organisation scholars mostly coming from sociological traditions have studied the body, and the main approaches I identified in the literature (2.4). These are: phenomenological approaches based on the work of Merleau Ponty (1962); approaches based on Shilling's 'body work'

(1993) and aesthetic labour; approaches that oppose a male 'norm' to a feminine 'other', mostly in the workplace; and approaches based on Foucault's work on power, knowledge, and discourse (1972; 1975; 1978; 1980). I further stress how this thesis is aligned with the last approach, due to the acknowledged constitutive nature of discourse in relation to gender and/in organisations, as well as its ability to legitimise organisational practices. I also note how organisation scholars have so far not focused on how organisations can construct the body in order to maintain their social acceptability or legitimacy.

In section 2.5 I presented how the female body in relation to reproduction is examined within organisation studies, and pointed out that this literature primarily studies the female body in its fertile state (either pregnant or maternal), and when employed by the organisation (see Gatrell, 2007; 2013). I conclude by stressing how, at the present moment, from the review of the literature I have carried out, I am unaware of the presence of a) studies that analyse how organisational fields, rather than single organisations or occupations, construct or relate to the female body; b) studies that centre on the reproductive body, particularly as product and outcome of a field's activities; and c) organisation studies works that focus on the female body that is infertile or not reproducing.

In light of the overall absence within organisation studies of analyses on discourse and FCEs; the body and legitimacy; on organisational fields and gender or reproduction; and on FCEs as discursive spaces that maintain legitimacy, in this thesis I am concerned with the following research question: *How do Field-Configuring Events discursively maintain field legitimacy?*

I ask how organisations attending the Fertility Show employ discourses of the female non-reproductive body to

maintain pragmatic, moral, and cognitive field legitimacy. In order to answer this overarching question, I ask 1) how the female non-reproductive body is discursively constructed by the organisations attending the FCE; 2) because discourse takes place within positive relations (see section 2.2.3.) and is constitutive of relations of power (2.4), I ask what relations organisations construct to such bodies; and finally, 3) I ask how and why such constructions and relations maintain the organisational field legitimate at the FCE.

The next chapter presents the research context, and specifically introduces the emergence of the field of fertility treatment in the UK and how it gained legitimacy.

CHAPTER 3. RESEARCH CONTEXT: THE EMERGENCE OF FERTILITY TREATMENT

3.1. Introduction

This chapter introduces the historical and social context underpinning current discussions of the female reproductive body, and presents how the field of fertility treatment emerged and developed from the birth of the first IVF baby in 1978 until today. The chapter thus shows how the field has emerged and developed through a scientific breakthrough, the public reactions to it, and governmental intervention in the matter. The increased attention to and regulation of infertility have in turn fostered the birth of various organisations that entered a field that by 1990 had increasingly developed.

It was however through one of the field's FCEs, the Fertility Show, that the legitimacy of fertility treatment became more evident: suddenly, a two-day event hosting a multitude of organisations involved in fertility issues was available to anyone unable to conceive naturally. The FCE is here an event that shows that the field is configured by a variety of different organisations that, as I discuss in this chapter, emerged with different interests in relation to fertility treatment. It is important to stress that this chapter only focuses on the actors, discussions, and events that took place either *during* field emergence, or *right before* the field was established. I do not employ sources that historically precede field emergence; as I will specify in the methods chapter (chapter 4), such sources are used to answer if, how and why the discourses emerging at the FCE maintain field legitimacy.

This chapter presents an overview of infertility and fertility treatment in the UK (3.2) before discussing the birth of the first

test-tube baby in 1978, the impact it had on the public in 1978, and how concerns and anxieties around the ethics of reproductive medicine gave rise to increased calls for regulation (3.3). These in turn resulted in the publication of the 1984 Warnock Committee Report and in the subsequent passing of the Human Fertilisation and Embryology (HFE) Act in 1990 (3.4 and 3.5). The chapter further presents the organisation field's emergence in relation to the variety of different organisations that formed since the late 1970s, and how the field reached its current development and configuration presented at the Fertility Show (3.6). I conclude by showing how these events helped the field gain pragmatic, moral, and cognitive legitimacy (3.7).

3.2. Infertility and Fertility Treatment: An Overview

> "Medicine is no longer exclusively concerned with the preservation of life, but with remedying the malfunctions of the human body. On this analysis, an inability to have children is a malfunction and should be considered exactly the same way as any other." (Warnock Committee Report, 1984: 9)

According to the British Medical Association (BMA), one in ten couples are said to be infertile, and one in seven will have difficulties in conceiving (BMA, 2012). Fertility treatment has resulted in 122,043 babies born following IVF in the UK between 1992 and 2006, with IVF births accounting today "for just over 1.5 per cent of all babies born in the UK each year" (BMA, 2012: 311). In 2011, 2 per cent of all babies born in the UK were conceived through IVF (HFEA, 2014). The age of women able to access treatment from the National Health Service (NHS) has increased to 42 (HFEA, 2013), and there has also been an increase in same sex couples receiving treatment (HFEA, 2014). Despite these recent social, cultural and legal changes, fertility

treatment still gives rise to important social and moral issues related to access to treatment, the beginning of personhood, and in general to public expectations of the outcomes of practices such as IVF (BMA, 2012; Harris and Holm, 1998).

Before engaging further with fertility treatment in the UK, it is important to define the concept of infertility and its current definitions. The NHS defines infertility as "when a couple cannot get pregnant (conceive), despite having regular unprotected sex" (NHS, 2014). At the international level, the definition of the World Health Organization (WHO) considers infertility "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse" (WHO, 2014). Legislation on Assistive Reproductive Technologies (ARTs) has seen a slow development in Europe, mostly due to the different religious, political and ethical viewpoints from country to country. Nonetheless, the areas where most disagreement is to be found are "eligibility criteria for access to assisted reproduction, gamete and embryo donation, and in vitro embryo research" (Pattinson, 2003: 7).

In the United Kingdom, the Warnock Committee first created a report on Human Fertilisation and Embryology in 1984, which constituted the basis for the Human Fertilisation and Embryology Act (1990). The Act, in turn, established the Human Fertilisation and Embryology Authority (HFEA), which is the main national regulator in the field, operating at an arm's distance with the Department of Health. The Act also establishes the activities needing licensing in order to be legally performed in clinics and hospitals – such as "the creation and use of human embryos in vitro for both treatment and research; the storage of gametes and embryos; the use of donated

sperm, eggs or embryos" (BMA, 2012). As a result, the HFEA liaises with every NHS and private clinic offering licensed fertility treatment. Both documents are further discussed in sections 3.4 and 3.5.

The increase in the number of people obtaining fertility treatment gives rise to reflections about products and services (fertility treatments, drugs, and surgical procedures) that have become more and more normalised as social norms around family and gender roles change and develop. As noted by Franklin, "[c]onception in vitro is now a normal fact of life" (2013: 1): if, only a few decades ago, giving birth following fertility treatment was conceived as a 'miracle' of science, today it is conceived as normal practice, something one would naturally seek when pregnancy does not happen (Moore, 1999). This normalisation has to do with both socio-cultural changes in civil, legal and medical rights (for example, same-sex couples, single women, or 'older' women obtaining treatment and being able to be recognised legally and socially as parents), but also with the various organisations revolving around fertility products and services, be they medical, scientific, profit-driven, governmental or societal. These interactions are important in relation to field legitimacy, in that the normalisation of an ethically sensitive field such as fertility treatment is linked to the same field's social acceptance: the more its practices are normalised, the more they are accepted and can therefore be carried out within the field.

The first clinic exclusively dedicated to IVF was opened in 1980 by Steptoe and Edwards, the same pioneers who only two years earlier achieved the very first IVF live birth (Bourn Hall, 2016; see 3.3). Thirty years later, in 2010 the UK had 71 fertility clinics (HFEA, 2011). In an article on the history and

development of IVF, Brian notes that at the time when fertility clinics were newly opened

> "IVF was far more demanding for patients than it is today. Women were required to spend two to three weeks as inpatients, staying in Portakabins in the grounds of their clinic … Today, IVF is a far more streamlined process. Women are treated as day patients, and there are no three-hourly urine collections, no hours of crouching after egg collection. Although moral and ethical questions still surround new advances, for the most part it has become an everyday treatment." (Brian, 2013)

The process has in time become less of a commitment, less time- and energy-consuming, and can thus be viewed as more of a 'normal' practice. In the last forty years, fertility treatment has indeed become normalised and standardised in line with industrial and medical developments, and the rise of fertility-related businesses can attest to this.

Particularly in light of the dependence of fertility treatment upon scientific and technological developments, the field becomes relevant when considering the types of organisations involved with reproductive medicine. Fertility treatment is a field primarily comprised of businesses which employ scientific developments in their practices, either directly (private clinics, pharmaceutical companies) or indirectly (as for instance in the case of counsellors supporting patients undergoing treatment). Reproductive medicine is directly and indirectly practiced through the organisations within the field of fertility treatment; in turn, the field would not exist without scientific and technological advancements. Anne Balsamo notes that

> "the technological formation of new reproduction technologies reproduces the process of biological reproduction as a commodity that can be institutionally regulated just as are other commodities. The emergence of a reproductive medical industry attests to the fact that the business of life has never been better." (Balsamo, 1999: 94)

Analysing fertility treatment as a field, then, is appropriate given its organising and reproducing features within society and culture. As I mentioned in section 2.2.3, a field is a construct employed to examine "social systems and processes" (Scott, 2008: 223): within a field, organisations "involve themselves with one another in an effort to develop collective understandings regarding matters that are consequential for organizational and field-level activities" (Wooten and Hoffman, 2008: 138). In the case of fertility treatment, the process of developing collective understandings of infertility commonly takes place within the marketplace: in fact, acknowledging infertile women and men as an expanding market helps understand how fertility has developed to be conceived a "health problem of concern to all" (Moore, 1999: 81). In this regard, Franklin stresses how IVF derived "from the narratives and hopes of couples seeking children – indeed from a technology that quickly became a new norm of family life" (Franklin, 2013: 31-32). Organisations' influence at the field level is here clearly intertwined with the broader social context where discussions on fertility take place. Moore further notes how "bizarre" it is to see fertility treatment advertisements in "mass-market publications" (Moore, 1999: 83), making it not just a normalised service, but a product seemingly easily accessible and obtainable by anyone trying to conceive. Such a

process of normalisation and commodification often obscures the mutually reinforcing relation between medicine and business, as well as the polarised positions of ART customers and health professionals. In fact, while both doctors and infertile people aim at the birth of a child, "their reasons for wanting this child clearly differ" (Pfeffer, 1987: 84), contrary to the common assumption of 'working together' to have a baby. The fact that the field of fertility treatment largely operates within a market becomes evident at the FCE level: most of the organisations exhibiting at the Fertility Show are businesses (see chapter 4), making them important actors when analysing field legitimacy.

Organising assisted reproduction can thus be linked to the "rise of health consumerism" (Bradby, 2012: 123) where different societal actors are involved in the market of health – from governmental investments "in individualizing responsibility for health and illness" (Bradby, 2012: 123), to pharmaceutical companies marketing their products to GPs and individuals. It is important to stress the consumeristic aspect of fertility treatment in that at the Fertility Show the profit-oriented nature of the vast majority of the exhibiting organisations is evident and rather stark; the legitimacy of the business side of the field of fertility treatment is related to broader social trends that have seen an increase in privatised healthcare and medical services. Indeed, "IVF is normal because it already belongs to techniques of normalization – including, among others, those of marriage, kinship, gender, scientific progress…consumer culture, and medical technology" (Franklin, 2013: 6). Fertility treatment, as a field mostly comprised of profit-oriented organisations, partly owes its

legitimacy to relatively recent broader social trends toward the privatisation of healthcare.

Despite the increased discussions and publications on fertility in recent years (Cahn, 2009; Henig, 2004; Ikemoto, 2009; Goodwin, 2010), fertility treatment started to become of public interest only in the late 1970s. Specifically, what sparked the creation of various fertility-related organisations was a scientific breakthrough: the birth of the first IVF baby on 25th July 1978. The next sections in this chapter are dedicated to presenting how the field of fertility treatment emerged, developed, and became legitimate through scientific advancements, regulations, and an increased market presence.

3.3. 25th July 1978: A New Kind of Baby

On the 25th July 1978, the first IVF baby was born at the Royal Oldham Hospital in Lancashire. The birth of Louise Joy Brown was the result of years of scientific experimentation and represented a landmark in reproductive medicine as well as for science more generally, and was achieved thanks to the collaborative efforts of Robert Edwards and Patrick Steptoe. Dr. Robert Edwards, winner of the Nobel Prize in Physiology and Medicine for his successful developments in IVF, had an educational background in animal reproduction and genetics (Franklin, 2013) before dedicating his research endeavours to physiology and experimental embryology in the 1960s. In 1966 he began his collaboration with Dr. Patrick Steptoe, a gynaecologist at Oldham General Hospital who pioneered "the development and use of the laparoscope in gynaecological surgery" (Johnson, 2011: 254). Their work was part of a stream of research into reproductive medicine linked to the names of Gregory Pincus and Min Chueh Chang.

Gregory Pincus (1903-1967) was an American biologist interested in the study of hormones and who famously contributed to the development of the oral contraceptive pill together with his colleague Min Chueh Chang. Pincus experimented and successfully achieved fertilisation in-vitro with rabbits (1930), whereas Chang successful achieved fertilisation in mammals such as rats, mice and hamsters (Franklin, 2013). Both scientists had a strong impact on reproductive science, and their work largely contributed to the research and achievements later carried out by Edwards and Steptoe. Pincus had in fact successfully cultured mice eggs and later in-vivo maturation of human eggs (Franklin 2013: 144). Edwards was motivated to carry on Pincus' work. In the 1960s he gained access to Edgware General Hospital in North London, where he was able to access "a reliable supply of human tissue from which to retrieve and mature eggs" (Johnson, 2011: 250). It is here that in 1969 and 1970 Edwards obtained his first significant achievements, by collecting "in-vivo matured eggs from follicles after mild hormonal stimulation" and later by "achieving regular fertilization of these eggs and their early development through cleavage to the blastocyst" (Johnson, 2011: 258).

Despite the scientists' professional and scientific achievements, the controversial status of reproductive medicine at the time (Johnson and Elder, 2015; Franklin, 2013) brought the UK Medical Research Council to reject the scientists' grant application in 1971 (Johnson, 2011). The rejection was mostly related to ethical concerns related to "the need for more animal and primate research" and concerns about the use of women for "purely experimental purposes" (Johnson and Elder, 2015: 42). At the time, Edwards particularly received a lot of

professional attacks due to the general lack of concern with regards to the ethics of the embryo on the scientific and medical community side (Johnson, 2011). However, strong in his will to change and influence public attitudes toward fertility treatment, Edwards publicly engaged with the media and openly discussed his work and research. The public and the medical establishment were nonetheless generally unwilling to take these engagements and discussions seriously. They only became of true interest to the Medical Research Council (MRC), the BMA, the Royal Society and the government after the birth of Louise Brown in 1978 (Johnson, 2011).

The ethics behind the first successful IVF birth story are of particular interest to understand how the field of fertility treatment emerged and developed. Elder and Johnson recently published a series of papers reporting the medical, scientific and ethical context at Oldham from 1969 to 1978 based on original documents recorded at the time (see Elder and Johnson, 2015a; 2015b; 2015c; Johnson and Elder, 2015). The authors note that the BMA was concerned about the ethics of embryo research at least until 1970, but became more enthusiastic later in 1972 after evidence provided by Steptoe and Edwards in relation to information for and treatment of patients before the procedure, risks in implantation, outcomes and methods (Johnson and Elder, 2015). Indeed, ethical concerns and practice came to the fore more broadly only in the early 1970s. Within the establishment, the use of research ethics protocols was rare until 1967 when the approval of a committees of doctors was suggested prior to all clinical investigations. The implementation of ethics committees was however notably slow (Johnson and Elder, 2015). Another reason for the "emergence of bioethics" during these years came from concerns with the

protection of the medical profession in light of the increased public and governmental preoccupation with medical ethics. Such concerns came from the government, but also from patients (who later became consumers), religious groups, and feminists (Johnson and Elder, 2105: 42).

If we consider the 1970s as the early days of the field's emergence, we can notice how the reasons underlying the increasing public interest in the field were related to the medical profession's interests as well as civil society concerns which, as I will discuss later in this chapter, were mostly related to issues of women's agency and the status of the human embryo. Edwards and Steptoe's approach to research and ethics was nonetheless very open, overall. The two published their results widely and in detail, and they engaged in public discussions (Johnson and Elder, 2015). Johnson and Elder further stress how, ethics-wise, the atmosphere at the Oldham clinic was permissive, most likely due to Steptoe's influence and charisma (Johnson and Elder, 2015: 42).

With respect to this last point, the authors mention important ethical issues with regards to the vulnerability of patients, remarking how women being treated at the clinic were often described as 'desperate', and how their condition and treatments were kept secret even from the women's families. The authors further question whether the women involved in treatment consented to it "validly under the common law requirement of capacity, information as to nature and purpose, and voluntariness" (Johnson and Elder, 2015: 42) or if it was instead a consent given on a vulnerability basis.

The ethical concerns that arose with the birth of Louise Brown were clearly not confined to the medical and scientific

professions. Much public anxiety was indeed present throughout society. The first IVF birth was described by biochemist Professor Leon Kass, who later became chairman of the US President's Council on Bioethics from 2002 to 2005, as "the blind assertion of will against our bodily nature, in contradiction of the meaning of human generation it seeks to control" which "can only lead to self-degradation and dehumanisation" (Frame, 2008: 132). The most vocal organisation against IVF was possibly the Catholic Church, which was strongly opposed to experimentation on human embryos, seen as human beings entitled to the same treatment as adults.

After the birth of Louise Brown, the early 1980s were a moment of strong reflections with regards to IVF, particularly with regards to the upcoming document submissions to the Warnock Committee for discussion in the same years. Seen as "intrinsically immoral" IVF was seen as a practice which was disrespectful to human life and where "newly conceived human beings are regarded as expendable for these purposes" (Iglesias, 1984). Other concerns included "the relationship of the procedure to abortion and the danger that widespread use of in vitro fertilisation might lead to more dangerous forms of genetic manipulation" (The Tablet, 14th April 1979), as well as questions about the sanctity of marriage and of the family as an institution. Outside of the Catholic Church, other contemporaries at the time defined IVF as "an ethical slippery slope" which might "bring society to apocalyptic human reproductive processes" (Frame, 2008: 132). Indeed, it has been reported how Louise Brown's family received threats and hate mail after their daughter's birth (Ward, 2015).

3.4. An Anxious Matter: The 1984 Warnock Committee Report

In light of much public turmoil, in 1982 the UK Government called for a committee chaired by moral philosopher Mary Warnock in order to bring to the fore recommendations on the ethics of IVF and reproductive medicine. Many societal organisations were invited to submit evidence to the committee, including a large number of hospitals, LGBT organisations, different churches, and women's organisations. The submitted documents included strong anti-choice organisations as well as more liberal ones. The HFEA stresses how the role of the committee "was to develop principles for the regulation of IVF and embryology" (HFEA, 2016c).

The committee met in 1984, and the results of its discussions were published in a report in 1985. The report explains the reasons for the committee's existence; the scope and organisation of infertility services; presents a 'number of techniques for the alleviation of infertility'; and discusses 'possible future developments in research' and the regulation of 'infertility services and research' (Warnock Committee Report, 1984: vii). Indeed, the strong public anxiety at the core of the committee's establishment is acknowledged at the very beginning of the report, which states that "feelings among the public at large run very high in these matters; feelings are also very diverse; and moral indignation, or acute uneasiness, may often take the place of argument" (Warnock Committee Report, 1984: 1). The committee's ethical commitment was paramount, so much so that its conclusion is primarily in relation to the status of the human embryo rather than explicitly recommending practices and detailed regulations for infertility-related organisations (Pfeffer, 1993; Warnock Committee

Report, 1984). The committee's conclusion is that "the embryo of the human species should be afforded some protection in law" (Warnock Committee Report, 1984: 63); however specific guidelines as to what kind of protection is needed were not provided. Another key recommendation concerns "the establishment of a new statutory licensing authority to regulate both research and those infertility services which we have recommended should be subject to control" (Warnock Committee Report, 1984: 75), namely artificial insemination, IVF, egg donation, and embryo donation. Five years later, the Human Fertilisation and Embryology Authority was established.

The Warnock committee represents a point of encounter of different ethical stances with regards to IVF, the beginning of human life, and what legal protection should be granted to the human embryo. However, the committee also represents a moment of disruption, in that despite the number of anti-abortion civil society organisations providing evidence to the committee for discussion, the direction taken from 1984 onwards with regards to reproductive medicine has been more liberal than conservative. Indeed, the 1990 Human Fertilisation and Embryology (HFE) Act emerging from the committee's discussions had a liberal tone that brought us to the IVF reality we know today: coupled women, straight women, lesbian women, single women, and 'older' women can all access treatment and decide what is to be done with the eventual 'left over' embryos and eggs regardless of their marital status.

Before the 1970s' scientific advancements in IVF, public discussions were focused on fertility and the (un)willingness or ability to have children, rather than the inability to do so. Consequently, debates focused on women's rights over their bodies and the role of medicine in this regard. However, much

debate came from religious organisations and the Catholic Church in particular. Despite an encompassing position against abortion and contraception taken by most churches and religions, the Catholic Church voiced louder concerns and took a very proactive stance in delivering their messages in support of the sanctity of human life (beginning at conception), of motherhood, of the bond between mother and child, and of heterosexual marriage.

In 1984, Catholic newspaper The Tablet provided rich accounts and articles on Catholic submissions to the committee voicing their "total unanimity on the principle of respect for the sacredness of every human life from its beginning at conception" arguing that "most of the current practices in IVF are blatant denials of this principle [the value of human life]" (Iglesias, 1984). However, the documents submitted to the Committee showed broader acceptance in relation to the so called 'ideal case' or 'straight case' for IVF: this meant an acceptance of the use of IVF only for straight married couples who sought "alleviation of their infertility by means of IVF" (Iglesias, 1984).

Despite the Church's conditional openness to IVF practices, other civic organisations did not accept the Committee's recommendation expressed in the final report. An example of these is the Association of Lawyers for the Defence of the Unborn (ALDU), which had been historically against most forms of contraception and abortion, and argued for stricter regulations post Warnock Committee Report to protect the human embryo (ALDU, Winter 1984 Newsletter). The organisation promptly quoted part of the speech given by Lord Rawlinson of Ewell during the Committee's meeting, that reads

> "If society permits some of its members to treat human life in accordance with the proposals of this report, we move inexorably down a path which will lead to a monstrous society, ultimately of fabricated creatures'" (ALDU, Spring 1985 Newsletter)

Indeed, anxieties did not subside after the Report, and IVF techniques were compared to international horrors such as the Nazi use of eugenics and slavery. With regards to Lord Soper's support of IVF, ALDU stresses how the principle "that the embryo is of less 'value' than the adult, and therefore may legitimately be destroyed, if this is considered to be in the interest of the adult… is capable of infinite extension, as has been proved in our own century by the horrors of Nazi medical and surgical experiments" (ALDU, Spring 1985 Newsletter). Concerns of ownership of the human embryo brought the organisation to compare IVF techniques to the slave trade, as they implied "rights of ownership over human beings" (ALDU, Spring 1985 Newsletter). Strong criticism against the Report was also presented in Higginson's article 'What's Wrong with Warnock', published in Anvil, a renowned journal of Biblical Studies (1985), who called the report "a sloppy piece of work" (1985: 10) and stressed the threats to the child, to marriage, and to the human embryo IVF was posing.

Feminist positions against IVF and reproductive medicine also emerged in the same years. In 1985 the Feminist International Network in Resistance to Reproductive Genetic Engineering (FINRRAGE) was established to give voice to a number of feminist positions questioning the use of reproductive technologies (Becker and Becker, 1992). Some of their arguments included IVF's redefinition of birth "as 'reproductive engineering'…in which the primary objective is *not*

to assist the female body in its body business, but to eliminate paternal uncertainty" (Balsamo, 1997: 94). FINRRAGE feminists have suggested that women involved in reproductive medicine are reduced to 'living laboratories' (Rowland, 1985) and 'mother machines' (Corea, 1986). Through reproductive technologies, their bodies are scrutinised, deprived of any privacy, manipulated, opened, and disembodied (Williams, 1997). However, the network encountered some feminist opposition. Not only, it was argued, was FINRRAGE assuming that "technological knowledge somehow overdetermines human choices" (Balsamo, 1997: 96); it also took a view of natural reproduction that did not match with many women's experiences. Feminist opposing FINRRAGE argued that not every woman felt like a passive 'mother machine', but that some women did want to access treatment and become mothers, and did not feel oppressed by reproductive medicine. In particular, Sawicki and Wajcam argue that reproductive technologies "are not monolithic structures that impose a singular reality or set of consequences on all women equally" (in Balsamo, 1997: 96). FINRRAGE also includes more liberal approaches that accept reproductive technologies as long as the women involved are fully informed about the process (Becker and Becker, 1992).

It is nonetheless worth noticing how, throughout the moments leading to the Warnock Committee's Report, the woman's body was *already invisible*: the core issues to be discussed were not as much about her infertile body or reproductive rights, but the embryo, the future life, and the welfare of the future child. The woman was primarily considered in relation to her health and the one of the child she was about to bear, which thus positioned her at the centre of public

concerns only when health risks involving treatment were present. Upon close reading of the Warnock Report, it starts to become clear how during field emergence the woman and her non-reproductive body were primarily publicly considered under just one condition - if medicine considered her at risk. Otherwise, the embryo would come first. In 1985, then, the female non-reproductive body does not seem to be at the centre or margin of public discussions on reproductive medicine. The field of fertility treatment was thus starting to obtain moral legitimacy by virtue of preoccupations with the ethics of the human embryo rather than preoccupations with the woman's body and fertility.

3.5. The 1990 Human Fertilisation and Embryology Act and the Human Fertilisation Embryology Authority

The 1990 Human Fertilisation and Embryology Act was drafted after the publication of the White Paper 'Human Fertilisation and Embryology: A Framework for Legislation' in 1987. The Act was intended to

> "make provision in connection with human embryos and any subsequent developments of such embryos; to prohibit certain practices in connection with embryos and gametes; to establish a Human Fertilisation and Embryology Authority; to make provision about the persons who in certain circumstances are to be treated in law as the parents of the child; and to amend the Surrogacy Arrangements Act 1985" (1990 c.37: 1)

The document lists the activities governed by the act; the functions and procedures of the authority; the scope of licenses and license conditions and code of practice; amendments of

laws on surrogacy and abortion; conscientious objection; and enforcement, among others (1990 c.37). The Act provides important definitions in relation to IVF, such as the definition of embryo, mother, and father. With regards to embryo creation, the Act "applies only to bringing about the creation of an embryo outside the human body" (1990 c.37: 1). Such creation can only take place where a licence has been granted by the Authority set up by the Act, the Human Fertilisation and Embryology Authority (HFEA). The Authority is a non-departmental body working at arm's length from the Department of Health, and it is the national regulator and inspector with regards to fertility treatment and research. At the time, the HFEA was the first one of its kind to be established (HFEA, 2016d). Further areas of concern are the welfare of the to-be-born child and of living children, conditions of storage of gametes and embryos, the creation of a code of practice to be given to service providers for the welfare of children, and the permission of conscientious objection to the practice.

In 2008 the HFE Act was amended to introduce changes with regards to parenthood laws and how same-sex couples are registered in the birth certificate of the child born as a result of IVF treatment. From 2009 both the mother's and the female partner's names are included in the birth certificate. This is also applicable to unmarried couples and same-sex couples in relation to children born through a surrogate (HFEA, 2016e).

Today, the HFEA represents a central point of reference not only for clinics that carry licences and are inspected by the Authority, but also for prospective and current patients needing accessible information on the various procedures available. The Authority maintains contacts with the main infertility NGOs and regularly engages in public events on the matter (HFEA, 2016f).

As in the case of the 1984 Warnock Committee Report, the establishment of the HFEA was primarily underpinned by ethical concerns on the embryo and on the activities clinics were allowed to perform. The clear focus is on service providers rather than on the bodies reproductive medicine intervenes into.

The HFEA is however essential for clinics in that it is the one organisation granting them a license to provide and perform fertility treatment. The HFEA further maintains contacts with key professional associations and NGOs in the field. From its establishment in 1990, fertility-related organisations started to emerge.

3.6. Towards the Fertility Show: The Development of a Field

As I mentioned in section 2.2.3, a field is a construct whereby organisations "involve themselves with one another in an effort to develop collective understandings regarding matters that are consequential for organizational and field-level activities" (Wooten and Hoffman, 2008: 138). Fertility treatment is a field in which many organisations from both the private and the public sectors co-exist and interact; ART regulation and practices are managed and carried out by the government, NGOs, private clinics, professional associations, and other businesses.

I have mentioned how the government is a highly involved organisation in the field's regulation and ethical discussions (mostly through the work of the HFEA), and also how the businesses involved in fertility treatment are mostly private clinics, smaller businesses providing products and services to prospective and current patients, and pharmaceutical

companies. Interestingly, private clinics do not need to follow national regulations and guidelines around fertility, but they do need a governmental license in order to provide their customers with fertility treatment. This happens in contrast to NHS clinics, which are required to follow the National Institute for Health and Care Excellence (NICE) guidelines when treating individuals diagnosed with fertility issues (NICE, 2015). For instance, the NICE guidelines require NHS clinics to offer women treatment up to the age of 42. Because private clinics do not need to follow NICE's regulations, they can go beyond such age limit at their discretion (NHS, 2016).

Together with the government and private clinics, civil society organisations represent yet another key player in this field. The role of fertility NGOs in working with the government and establishing relationships with companies involved in the field has become increasingly relevant. These organisations include patient support groups, national campaigns and initiatives aimed at informing and supporting people before, during, and after fertility treatment. These initiatives also revolve around reproductive issues that usually do not get much public attention, such as for instance the Miscarriage Association (Miscarriage Association, 2016).

Due to their closeness to people undergoing treatment, NGOs have thus become very proactive, aiming to put people's experiences first (see NGOs Infertility Network UK, 2015; ACeBabes, 2015; More to Life, 2015). In the context of reproductive medicine, the organisation field is built around various fertility-related issues, so much so that a number of organisations dedicated to specific reproductive issues have been created (see for example Childlessness Overcome Through Surrogacy (COTS) in 1988, The Miscarriage

Association in 1982, and the Donor Conception Network in 1993) (COTS, 2016; The Miscarriage Association, 2016; Donor Conception Network, 2016).

Among these NGOs, Infertility Network UK (IN UK) plays a pivotal role in providing assistance and information to infertile people. The organisation was founded in 2003 with the merging of two charities: Issue, founded in 1977, and Child, founded in 1979. The NGO is further comprised of the initiatives ACeBabes, in support of those who have become parents after experiencing fertility issues, and More to Life, in support of the involuntarily childless (IN UK, 2016; The Working Parent, 2016). IN UK is 'the face' of the Fertility Show and thus its presence within the field is central.

Professional associations such the Association of Clinical Embryologists (ACE), the British Andrology Society (BAS), the Association of Biomedical Andrologists (ABA), and the British Infertility Counselling Association (BICA) are also important actors with regards to the circulation of knowledge among central organisations in the field. These associations work together by providing information related to reproductive health; for example, material produced by BICA about the various treatments available often refers to ACE as a source of knowledge (BICA, 2015). BICA was founded in 1988 for fertility counsellors and aims to "address the many practical, social, psychological and ethical issues around the treatment of assisted conception" (BICA, 2016). ACE was founded in 1993; BAS in 1977; ABA was instead formed more recently, in 2004. These professional associations are collectively present at the Fertility Show under the name of UK Professional Fertility Societies. Their presence at the event is thus important but concentrated: unlike private clinics that will have a stand each,

professional associations share the same space and deliver their material to the Show's attendees.

Overall, the field of fertility treatment in the UK includes five types of organisations: the government, represented by the HFEA and positioned at the centre of the field due to its regulatory functions; private clinics, also at the centre of the field as primary providers of fertility services; NGOs, with IN UK at the centre of the field due to its nationwide presence, and other smaller NGOs at the periphery; professional associations, somewhat in between the centre and the periphery of the field due to their large presence in the medical and scientific domain but less public engagement; and other fertility-related businesses located at the periphery of the field due to their lack of field-wide legitimacy, such as in the case of astrology or yoga businesses providing products and services aimed at enhancing the patients' chances of success. Most of the central organisations were formed from the late 1970s, just before or after the birth of Louise Brown, to the early 1990s, after the creation of the HFEA. These two decades allowed for field legitimacy to be established due to a mixture of scientific and medical developments and public concerns in relation to the human embryo.

A strong example of the field's gained legitimacy is represented by the Fertility Show. Created in 2009, the Show has been referred to as "the Ideal Home exhibition for making babies" (The Standard, 21st October 2009) and was acquired by River Street Media, an exhibition organising corporation, in January 2016. The website dedicated to the Show states that "[s]ome of the team have their own personal experience with fertility issues, so understand first-hand what a difficult journey this is" (Fertility Show, 2016a). The reader is also reminded that

"there is no other event where you can meet so much fertility expertise in one place, at one time" (Fertility Show, 2016b).

The year 2015 saw the attendance of 3,500 "paying visitors" over the two days dedicated to the event (Fertility Show Exhibitor Pack, 2016: 2). Stands can be booked by IVF clinics and egg banks, non-IVF organisations, and NGOs. A show guide is given to participants and it is described by the webpage of the event as providing "a targeted promotional opportunity for advertisers" (Fertility Show, 2016). The page further stresses how "[t]he shows are an ideal platform to engage with and increase brand exposure to an extremely targeted, niche audience who are looking for answers and treatments to help them on their fertility journey" (Fertility Show, 2016). The list of welcomed exhibitors includes "Fertility clinics – UK and overseas; fertility assessment and investigation; information and advice groups; charities and patient care groups; sperm banks and donor agencies; holistic and complementary practitioners; acupuncture, yoga & massage therapists; diet, nutritional and lifestyle advisors; stress, smoking cessation and weight-loss advisors; infertility counsellors; surrogacy advisors; pregnancy and ovulation testing; adoption and fostering agencies; supplements and vitamins; publishers …and anyone offering products, services or advice that can help improve the chances of conception" (Fertility Show Exhibitor Pack, 2016: 4).

The Show's marketing campaign is based on the distribution of advertising and inserts in "women's press, health titles, parenting titles, lesbian and gay titles, outdoor media, patient care magazines" (Fertility Show Exhibitor Pack, 2016: 5) and direct marketing to fertility clinics, fertility patients, patient care associations, charities, "[a]nd all available routes

to medical specialists working in fertility" (Fertility Show Exhibitor Pack, 2016: 5). Online marketing and "the placement of case studies and interviews with speaker and exhibitors" are included too.

Public accounts provided by individuals who attended the Show are, on the other hand, fairly rare. On a number of occasions, newspapers have published articles on the Show stressing the peculiar marketplace atmosphere concurrent with the vast amount of specialised information available to attendees (Cook, 2009; Williams 2010). Fertility Coach and Show attendee Dee Armstrong published a blog post in 2015 describing the Show as being

> "set up exactly like a wedding show - stands all laid out on the enormous floorspace, offering you a shopping experience quite unlike any other, on everything fertility related. There are many IVF clinics from both the UK and overseas, various fertility charities, companies offering ways to help you finance your fertility treatment, a host of complementary therapies and a few more flaky sounding enterprises - fertility astrology - who knew? At first it all seems very weird and slightly unsavoury. There is the distinct whiff of profit making companies trying to land a sale. And that's sad when you know that many of the couples there are feeling pretty desperate and willing to try anything, which must leave them vulnerable." (Armstrong, 2015)

We can understand the creation and development of the Fertility Show as somehow confirming fertility treatment's legitimacy, which was possible through a broader involvement

with businesses in the field rather than with governmental or civil society organisations. Thus we can see how field legitimacy started in the late 1970s with a scientific breakthrough; how it then developed through ethical preoccupations leading to governmental regulations; and how it finally increased in the last eight years through a higher focus on the business and consumerist features of fertility treatment. The obtainment of legitimacy was significantly influenced by the creation of the Fertility Show.

3.7. How Fertility Treatment Gained Legitimacy: Strategies and Types

In section 2.2.1 I mentioned how there are three strategies that organisations can employ to gain legitimacy: a) adaptation to the requirements of current audiences; b) choosing among different environments the one whose audience will more likely support the organisation's practices; and c) the manipulation of the organisation's environment "by creating new audiences and new legitimising beliefs" (Suchman, 1995: 587) and by creating "bases of support specifically tailored to their distinctive needs" (Suchman, 1995: 591).

From the account I provided in this chapter, we can see how the field obtained legitimacy through these three strategies. Specifically, organisations in the field *adapted* to the social requirements related to the ethics of the embryo through the creation of the Warnock Committee first, and later with the creation of the HFEA. We can also see the field's ability to cure infertility and render women fertile as an adaptation to society's requirements for women to be fertile and become mothers (see section 2.3). By creating the Fertility Show, the field also *chose an environment* that provides it with a supporting audience: as I cited in the previous section, on the Show's webpage we can

read that the event is "an ideal platform to engage with and increase brand exposure to an *extremely targeted, niche audience who are looking for answers and treatments* to help them on their fertility journey" (Fertility Show, 2016, italics added). The social norm that it is natural for women to reproduce (section 2.3) can also be applied to this second strategy: if a woman cannot naturally become a mother, then an organisational field able to render her fertile can be viewed as restoring her 'natural' role in society. Such a role was thus likely welcomed and not likely to be challenged by the field's environment.

Organisations also gained legitimacy by *manipulating their environment*, particularly by *creating bases of support centred around their particular needs*. From the 1970s until the early 1990s, the needs of the organisations in the field were strongly related to the social acceptance of their practices: practices which did not focus much on the intervention on women's bodies, but rather on the creation of embryos and on the creation of potential future life.

We can also see how organisations within the field obtained pragmatic, moral, and cognitive legitimacy. We can notice how private clinics obtained *pragmatic legitimacy* through the adoption of ethics protocols and assessments, primarily to protect the profession in light of public concerns coming from the government, the public, patients, and feminist and religious groups (Johnson and Elder, 2015). NGOs and professional associations gained pragmatic legitimacy by virtue of filling two gaps in the field: the former by providing non-medical support to people undergoing or interested in treatment; the latter by filling information gaps and providing prospective patients with technical information about treatment and counselling (3.6).

Moral legitimacy was instead obtained during field emergence thanks to the unchallenged social norms that saw women as 'desperate' to become mothers, and that viewed infertility as a taboo that encouraged medicine and patients alike not to publicly discuss women's infertility and attempts at treatment (Johnson and Elder, 2015; section 3.3).

As presented in section 2.2., *cognitive legitimacy* is the need for an organisation to obtain "affirmative backing" (Suchman, 1995: 582) from society. The existence of an organisation will thus need to be conceived as "necessary or inevitable based on some taken-for-granted cultural account" (Suchman, 1995: 582). By the 1990s and with respect to the field of fertility treatment, the cultural account that was not questioned, and thus was taken for granted, was that of the primary importance of the ethical and legal status of the embryo. This was most evident from the mid 1980s to the early 1990s, when public discussions and regulations increased and culminated with the creation of the HFEA. Because legitimacy is a process that adapts to social contexts and is thus evolving (Shocker and Sethi, 1974), the social legitimacy of these organisations, mostly established through regulations on the legal and ethical status of the embryo, had and still has to be maintained. The aim of the analysis I present in chapters 5, 6 and 7 is to show how this is done through discourse at the Fertility Show.

3.8. Conclusion

This chapter has presented how the field of fertility treatment has emerged and how it gained legitimacy from the late 1970s until today. I have discussed infertility and fertility treatment and provided a background with regards to their understanding and organisation in the UK (3.2), and then

proceeded to present the historical and scientific conditions that allowed for the first IVF baby to be born in 1978, as well as the public concerns the event caused (3.3). Section 3.4 was dedicated to the 1984 Warnock Committee Report in response to the increasing public anxiety stemming from advancements in reproductive technologies, whereas section 3.5 presented the 1990 HFE Act and the creation of the Human Fertilisation and Embryology Authority. I have introduced the Fertility Show, presented how the Show is marketed also towards exhibitors, and stressed the business-oriented mind set pervading the FCE (3.6). Finally, based on the information provided in the previous sections of the chapter, I detailed how the field of fertility treatment gained pragmatic, moral, and cognitive legitimacy (3.7).

The next chapter presents the methodology employed in the study to investigate how field legitimacy is maintained, and presents the approach taken to the analysis of discourse. It introduces the ontological and epistemological foundations of the research, and further presents the process of data collection and analysis before discussing issues of validity and reliability.

CHAPTER 4. RESEARCH PHILOSOPHY AND METHODS

4.1. Introduction

As presented in chapter 1, this thesis is concerned with understanding how organisations at a FCE employ discourses of the female body to maintain legitimacy. The literature review presented in chapter 2 highlighted how: a) within organisation studies, we know little as to how discourses are generated and employed at FCEs, and how such discourses can influence field legitimacy; b) within the four approaches identified in organisation studies and the body, the focus is maintained on the body at work or within the organisation, rather than paying explicit attention to the body as a central entity in itself; c) works within organisation studies and the female body in relation to reproduction have specifically analysed the fertile, pregnant or maternal body, particularly at work; and d) there is a lack of studies focusing on organisational fields and the body.

To address the presented gaps, the thesis addresses this primary research question: *How do Field-Configuring Events discursively maintain field legitimacy?*

In order to answer this question, I am further guided by the following research questions, specifically in relation to the organisational field of fertility treatment:
At one of the field's FCEs, the Fertility Show,
(1) How do organisations discursively construct the female non-reproductive body?
(2) What relations are discursively constructed between the organisations at the Show and the constructed bodies?
(3) How are these bodies and relations maintaining field legitimacy at the FCE?

These questions are to be answered by analysing organisations' use of discourse at the Fertility Show, here approached as a FCE that is defined by, and defining of, specific interactions and discourses (Hardy and Maguire, 2010). For the purpose of this study, I understand both concepts of organisations and bodies as being socially constructed. Further, discourse is here understood as constituting subjects and power relations. These assumptions in turn inform my methodological approach, which involves Critical Discourse Analysis (CDA). The methods used to gather data are qualitative, and include document analysis and observation.

In this chapter I discuss how data were collected, approached, and analysed following Norman Fairclough's three-level approach to CDA (1989/2001; 1992; see also 1993; 1995a; 1995b). Specifically, in this chapter I present how: a) the first and second research questions are answered through the collection of documents and observations at the Fertility Show to be analysed through Fairclough's approach to CDA; b) and the third research question is to be answered through Fairclough's social practice level of analysis, and utilises the outcomes from the analysis of a) to provide explanations as to how organisations at the Fertility Show maintain field legitimacy through discourses of the female non-reproductive body.

This chapter thus presents the ontology and epistemology informing the study (4.2); the analytical approach focussed on discourse, Discourse Analysis (DA), and CDA in particular (4.3); the analytical approach taken (4.4 and 4.5); the research design (4.6); the research methods used (4.7); the process of data collection and the analytical framework used to analyse data (4.8 and 4.9); and will conclude by discussing issues of

validity and reliability (4.10), critiques to and limitations of the approach taken (4.11), and reflexivity (4.12).

4.2. Ontological and Epistemological Principles informing the Study

This study is ontologically and epistemologically informed by principles of social constructionism. Whereas ontology refers to "the study of things that exist and the study of what exists" (Latsis, Lawson, and Martins, 2007 in Lincoln et al., 2011: 102) and has to do with the nature of reality (Creswell, 2007), epistemology is "the relationship between what we know and what we see" (Lincoln et al., 2011: 103).

A social constructionist approach specifically rests on a number of key principles, such as the challenging of "taken-for-granted knowledge" (Burr, 2003: 2), the historical and cultural specificity of events, and the intertwinement between knowledge and social practice. Social constructionists take a critical stance against the idea that knowledge is unbiased, and understand knowledge as being "fabricated" through interactions and social processes (Burr, 2003: 4). Consequently, meaning is constructed rather than discovered (Crotty, 1998; Searle, 1996).

Historical and cultural relativity are cornerstones of a social constructionist approach. In this study, the ways in which knowledges and constructions of the body are discursively created by organisations are understood as products of a specific Western historical and cultural context. This means that the constructions that I will discuss are specific to the research context in recent years, and are not assumed to be applicable to other societies or historical times. Further, social constructionism views language as constructing the subject and hence as having constitutive features (Burr, 2003: 17; Van Dijk,

1997; Wodak and Meyer, 2009). Language becomes a powerful tool which constructs the discourses through which we understand and experience the world, be it through texts, pictures, or images. This in turn leads to the production of social phenomena (Burr, 2003). Further, Fairclough argues that there is a distinct dialectical relation between what happens at the semiotic and linguistic level and what goes on at the social level, and vice versa (Chouliaraki and Fairclough, 1999; Fairclough, 2010): hence, what we say influences what we know, and what we know influences what we say.

By discourse I understand the "practices which form the objects of which they speak" (Foucault, 1972: 49), as I presented in chapter 2. The social construction of specific discourses gives rise to specific objects of knowledge and relations of power, and simultaneously creates opportunities for resistance. This power/knowledge nexus relates to the production of discourse and its control (or exclusion), which are both sustained by institutional and social practices (Foucault in Young, 1981). As Burr stresses, "discourses have implications for what we can do and what we should do" (2003: 75), and can be used to sustain "social relations of power and domination" (Fairclough, 1993: 139).

4.2.1. The Social Construction of the Body and of Organisations

The body has been described as a contested terrain (Grosz, 1995). Because of the social constructionist approach I take in this study, I am limiting the conception of the body in data analysis to its discursive constructions, to the way the body is talked and written about by organisations at the Fertility Show. Consequently, I see the field of fertility treatment as entailing a set of discourses that are fundamentally informed by the

discursive constructions of the body organisations create in their texts.

Organisations, too, are here understood as socially constructed (Berger and Luckmann, 1966; Pfeffer, 1981): the organisations involved in fertility treatment which discursively construct the body are in turn products of social processes of interaction and discursive construction in particular. This means that an organisation a) makes use of the available discourses on a certain matter in society (i.e. the provision of fertility treatment to all infertile individuals who can afford it), and b) endorses or challenges such discourses through text production and consumption (i.e. for instance by arguing against fertility treatment in the case of unexplained infertility).

4.3. Discourse Analysis (DA) and Critical Discourse Analysis (CDA)

Data are analysed using Critical Discourse Analysis (CDA). This section discusses key concepts in relation to this approach taken toward analysis: namely language, discourse, and Discourse Analysis (DA).

Social constructionists argue that everything we express is limited by what language enables us to do (Burr, 2003: 53; see also Butler, 1993). Discourse Analysis is an approach to qualitative data which focuses on linguistic features and that understands discourse in a variety of ways: as social interaction, as power, as communication, as natural language in use, as "contextually situated", or as a "complex, layered construct" (Van Dijk, 2011: 4). There are many different approaches to DA, and at least as many definitions of discourse. Tannen et al. highlight that "these definitions have in common a focus on specific instances or spates of language" (2015: 1). An important feature of DA is represented by the deconstruction

of the various levels and dimensions of discourse, and the practice of relating them to each other simultaneously. Van Dijk particularly stresses how discourse analysis constantly moves from micro to macro levels of text, talk, or context, and vice versa (Van Dijk, 1997: 32).

The notion of discourse has been defined as "essentially fuzzy" (Van Dijk, 1997: 1) due to the many different approaches to discourse studies. In this thesis, I use the definitions provided by critical discourse analysts, and in particular I follow Fairclough's early work (1989/2001; 1992), which is in turn influenced by the work of Michel Foucault (1972). Foucault defines discourse as "practices which form the objects of which they speak" (Foucault, 1972: 49). Wodak and Meyer more specifically describe it as "anything from a historical moment, a *lieu de mémoire*, a policy, a political strategy, narratives in a restricted or broad sense of the term, text, talk, a speech, topic-related conversations, to language per se" (Wodak and Meyer, 2009: 3). Following the social constructionist perspective I adopt, I understand what we say and write as manifestations of discourses, instances where particular discourses are constructing events. There is, then, a dialectical relationship between our talk and discourses, in that what we say and write is informed by discourses that surround us, and the discourses surrounding us show up in what we say and write (Burr, 2003; Fairclough, 1989/2001).

4.4. CDA

Whereas CDA shares some common principles with DA, the two approaches are fundamentally different with regards to their aims and focuses. First, CDA is not a sub-category of DA. Second, the separation from DA lies in the social and political issues CDA deals with, the constant move beyond description

toward explanation, and in its concern with how discourse reproduces or challenges unequal power relations in society (Van Dijk, 2015). Recently, Van Dijk specified that scholars have started addressing CDA as Critical Discourse Studies (CDS) in light of CDA being "a *social movement* of politically committed discourse analysts" (Van Dijk, 2015: 466) rather than a specific form of DA. In fact, CDA is neither part of DA nor "a special *method* of doing discourse analysis" (Van Dijk, 2015: 466), but rather an analytical critical perspective within discourse studies. Nevertheless, in this thesis I employ the more widely accepted and academically established acronym of CDA.

As "discourse study *with an attitude*" (Van Dijk, 2015: 466), CDA requires a methodological approach that is necessarily complex, often multi-method (Wodak and Meyer, 2009), and focussed on demystifying power and ideologies. Studies in CDA have developed into a variety of approaches, although the names of Van Dijk, Wodak, and Faiclough are often acknowledged as the most prominent authors to date (Van Dijk, 1997; see Van Dijk, 1993; 2011; Burr, 2003; Wodak, 1989; Wodak and Meyer, 2009; Fairclough, 1992; 1995a; 1995b; 1989/2001).

Before CDA takes place, the researcher is required to take a number of necessary steps related to the definition and clarifications of core concepts that will be used in the analysis. Words like text, discourse, discourse practice, social practice can take different meanings depending on the specific approach to CDA taken (Weiss and Wodak, 2003).

4.4.1. Characteristic Features and Main Approaches to CDA

Along with social constructionist principles, language in CDA is understood as social practice (Fairclough and Wodak, 1997; Burr, 2003; Fairclough, 1989/2001) and a vehicle for power which can be used to sustain and organise social life (Wodak and Meyer, 2009).

Because of the political underpinning of CDA, it is important for researchers to be open and upfront about the political aims of the study being carried out. Adopting a CDA approach allows the investigation of "the emergence of new orders of discourse, struggles over normativity, attempts at control, and resistance against regimes of power" by analysing "which discourse is being represented, respoken, or rewritten" (Blommaert and Bulcaen, 2000: 449). Hence the 'Critical' in CDA refers to the aim of moving beyond the act of noticing hegemonic dynamics in society in order to explicitly challenge them, allowing the researcher to "produce and convey critical knowledge that enables human beings to emancipate themselves from forms of domination through self-reflection" (Wodak and Meyer, 2009: 7). These intentions, in turn, call for reflexivity and openness on the part of the researcher throughout their work (Wodak and Meyer, 2009).

As previously mentioned, the main approaches found in CDA are the ones of Wodak (1995; 1996), Van Dijk (1988; 1993; 1997) and Fairclough (1992, 1993, 1995a, 1995b, 1989/2001, 2010). In this section I briefly present these different approaches, and clarify my decision to follow Fairclough's position.

Wodak's discourse-historical approach stems from the Vienna School of CDA, and is mostly informed by the work of

Habermas (1984). Discourse is understood as necessarily linked to other discursive events, taking place before or at the same time as the specific discourse that is being analysed. For this reason, discourse is always historical (Weiss and Wodak, 2003). Wodak sees context and text as equally important (Wodak, 1996) and suggests that all background information on the text should be analysed together with events that happened before and at the same time of the said text (Wodak, 1995).

Van Dijk's approach (1988; 1993; 1997) uses a socio-cognitive model, where sociocognition (the mental representations of individuals) acts as a mediator between society and discourse. When approaching the text, Van Dijk (1993) suggests the researcher analyses 1) the context of discourse; 2) the groups involved in the discourse and the relations among them; 3) if and how the polarization Us versus Them is taking place; 4) if such polarization is taking place, the critical discourse analyst should render it explicit, together with any other power relation that might be implied in the text; 5) and finally, all formal structures (grammar, syntax, semantics) should be examined in order to deconstruct and weaken the Us/Them polarization. Van Dijk's socio-cognitive approach achieves this by examining the text at the three levels of analysis, respectively discourse, sociocognition, and social analysis (1993).

The third approach to CDA is the one proposed by Fairclough (1989/2001, 1992, 1993, 1995a, 1995b), which draws from concepts originally theorised by Foucault (*discourse*) (1972), Gramsci (*hegemony*) (Gramsci, 1971), and Habermas (*colonisation of discourse*) (1984). This approach further seeks to relate the discursive to the extra-discursive (Chouliaraki and Fairclough, 1999) by analysing discourse on three levels: text, discursive practice, and social practice.

I hold that Fairclough's approach to CDA is best suited for the purpose of this study. Compared to Wodak's and Van Dijk's work, Fairclough's approach best allows me to 1) link the discourses taking place at the FCE with those taking place outside of it but nonetheless influencing the event and the discourses therein; and 2) select and 'mould' the analytical units and elements depending on the type of analysis I wish to carry out to best discover the imbalanced power relations in my data. What particularly renders this approach relevant to the thesis' aims is the author's understanding of discourse practice and social practice, which is starkly grounded in Foucault's approach to discourse. I explain this in detail in section 4.9.

4.5. Norman Fairclough's Approach to CDA

In this section I will present the main features of Fairclough's approach to CDA, and the terminology I will be using during data analysis and interpretation. Both these steps are considered of high importance within DA and CDA in particular (Van Dijk, 1997; Weiss and Wodak, 2003). Fairclough suggests a three-level framework to approach and analyse data, specifically a text analysis level, a discourse practice level, and a social practice level. This analytical process is only suggested: depending on the research context and questions, the analyst will maintain flexibility and openness in their approach.

The first level of analysis is that of *text analysis*, which deals with small units of analysis such as voice, participants, and transitivity in grammar, but also on the wording used in the text. It is primarily a descriptive step that allows for discursive constructions to emerge: text analysis is carried out to understand how something is being talked about through the use of specifically chosen grammatical elements. I utilise text

analysis to understand which discourses organisations employ and draw upon when talking about the body. I describe this level in detail in section 4.9.1.

The second level of analysis is that of *discourse practice*, which is instead concerned with text production, distribution, and consumption and is here employed to understand how text producers (organisations) use discourses emerged in text analysis to position themselves in relation to text consumers (prospective patients) (Fariclough, 1989/2001). This level requires more interpretation on the researcher's side; here, I select texts from a number of organisations where discourses of the body have emerged from text analysis, and investigate how such discourses are used by organisations to build relations with the prospective patient. Discourse practice is presented in detail in section 4.9.2.

The third and final level of analysis is that of *social practice*, which further zooms out to analyse how the discourses emerging through text analysis and discourse practice relate to the broader social, political, and/or historical context where the text is being produced and consumed. Social practice is here employed to understand how and why the discourses and relations emerging in text analysis and discourse practice are used by organisations (text producers) at the FCE to maintain field legitimacy. I describe this level of analysis in detail in section 4.9.3.

4.6. Research Design

The three research questions are answered through the employment of Fairclough's CDA, and in particular through text analysis, discourse practice and social practice respectively.

Table 3. Levels of Analysis and Research Questions

Level of analysis	Research Questions
Text Analysis	• How do organisations discursively construct the female non-reproductive body?
Discourse Practice	• What relations are discursively constructed between the organisations at the Show and the constructed bodies?
Social practice	• How are these bodies and relations maintaining field legitimacy at the FCE?

We can further understand each research question as being concerned with a specific research aim, namely:

Table 4. Research Questions and Analytical Aims

Research Question	Analytical Aim
1. How do organisations discursively construct the female non-reproductive body?	To show what discourses of the female non-reproductive body are employed by organisations attending the Fertility Show.
2. What relations are discursively constructed between the organisations at the Show and the bodies?	To show how organisations build relations with and position themselves in relation to the female non-reproductive body.
3. How are these bodies and relations maintaining field legitimacy at the FCE?	To show what historical and social factors explain how the female body is employed to maintain field legitimacy.

Each research question will be answered using the following sets of data and methods:

Table 5. Research Questions, Units of Analysis, Units of Observations, and Methods

Research Questions	Unit of analysis	Unit of observation	Method
1/ How do organisations discursively construct the female non-reproductive body?	Organisations exhibiting at the Fertility Show. *Text Analysis:* A total of 170 documents from: Government 12 private clinics 9 NGOs 2 NHS trust foundations 1 Professional Associations 12 Other businesses 8 seminar observations	Discourse.	Document analysis: text analysis.
2/ What relations are discursively constructed between the organisations at the Show and the bodies?	*Discourse Practice:* One full text from: 1 Governmental body 1 Private clinic 1 NGO 1 Professional Association 1 Other business Field notes (20hrs, two 2-day Fertility	Discourse.	Document analysis: discourse practice analysis. Observation.

	Show attendances)		
3/ *How are these bodies and relations maintaining field legitimacy at the FCE?*	Analysis and research outcomes from questions 1/ and 2/. Historical documents on development of birth control and ART in the UK; academic books and papers.	Discourse.	Social practice analysis: social contextualisation of text analysis and discourse practice 'findings'.

4.7. Methods

4.7.1. Qualitative Methods and Social Constructionism

Qualitative research is comprised of non-statistical data collection practices including document analysis, observation/participation, ethnography, case studies, interviews, and an array of ways of analysing the data gathered. These methods are widely used in organisation studies and research, including studies on organisations and the body (see Hassard et al., 2000), and studies primarily focusing on the body (Shaw, 2012; Bryant and Garnham, 2014; Brunner and Deven, 2014).

Qualitative research draws upon various philosophical assumptions and epistemological positions. Qualitative researchers agree nonetheless that the methods used by the natural sciences are not adequate to study social reality (Lee, 1993). Furthermore, the social constructionist approach taken in this study tends to reject the notion of objectivity when conducting research (Burr, 2003). This is done mainly in the

light of the researcher's bias toward the study, which has to be explicit. This emphasis on reflexivity is shared with CDA scholars (Wodak and Meyer, 2009). Because of its interdisciplinary nature, CDA welcomes a variety of research methods, which can be qualitative or quantitative (Burr, 2003). In this study, the methods I use are qualitative, and comprise of document analysis and observation.

4.7.1.1. Document Analysis

The analysis of publicly available documents represents the main source of data gathering in this study. The collected and analysed data include magazines, brochures, leaflets, marketing material, books and articles. Documents are considered social facts by virtue of being

> "produced, shared and used in socially organised ways. They are not, however, transparent representations of organisational routines, decision-making processes or professional diagnoses. They construct particular kinds of representations within their own conventions" (Atkinson and Coffey in Silverman, 1997: 47).

In line with the social constructionist perspective adopted in this study, documents are not considered an objective reality. Instead, they represent and construct specific discourses that are in turn historically, culturally, and socially situated. During analysis, it is therefore important to consider their context, authenticity, and access (Matthews and Ross, 2010). All the documents analysed are currently available publicly from direct sources, or from the organisations' websites or stands at the Fertility Show. The choice of documents reflects the aim of each

research question as well as the spectrum of organisations exhibiting at the Show: specifically, the documents collected are publicly available books, newspaper and journal articles, and texts produced by private clinics, the government, NGOs, and other fertility-related businesses.

4.7.1.2. Observation

Observation is "said to make no firm assumptions about what is important" (May, 2011: 163). This characteristic is related to the strong reflexivity and self-reflection qualitative researchers are expected to practise in the field (Skeggs, 2001). For the purpose of data gathering I attended the Fertility Show both in 2013 and 2014. Here I physically collected organisational documents available at the various stands, and attended a number of seminars on various topics related to infertility. The two experiences were very different and provided me with insightful observations and reflections. Observing the world around us is "brought on by the stimulus to be necessarily aware" (Sanger, 1996: 3), and importantly, we observe what our mind-sets want us to observe (Sanger, 1996). As per the knowledge the researcher should gather prior entering the field, two positions can be taken: the researcher can either attempt to gather as much information as possible, or as little as they can. Prior to my fieldwork, I knew little about what was going to happen at the Show. At the 2014 Show my understanding was more thorough, and my observational goals more defined. In 2013, I allowed myself to be surprised (even upset at times) about the amount and sort of information I was gathering. In 2014, I was more prepared: I knew who was exhibiting, who was going to be there, and the kind of discourses that were taking place. This second fieldwork allowed for new, different, and perhaps more challenging observations and questions to

emerge as to how certain dynamics occur. In the analysis, I employ my observations so as to provide further background and context to the organisational texts I analyse through CDA.

An important factor is the very short amount of time I had to collect a fairly dense set of data. The Fertility Show lasts two days and only takes place once every year, making me an observer only for a few intense days. This does not necessarily mean that I would have collected more data had I had the opportunity to spend more time in the field, but rather that it was a condensed and strong experience. Another challenging aspect of observation lies in the 'participant' feature. I did not actively participate in the Show, I was not exhibiting or intervening at the seminars, and I only engaged with exhibitors following full disclosure of my researcher status. However, when doing this type of research we are "walking the fine line" between how much to disclose about what we do, and how much to keep to ourselves for the sake of data authenticity (Sanger, 1996: 36).

Keeping this in mind, when researching in the field I only observed exhibitors and speakers, as a way of adhering to ethical codes of research with respect to prospective patients. I did not interact with them, nor did I intentionally observe them with the aim of collecting data. Of course it is impossible to completely ignore our surroundings, and inevitably I have perceived other individuals and have been aware of this. However, in order to behave ethically, I consciously avoided reflecting upon them as subjects of research, or as something to be studied and analysed. By ethical behaviour I mean making a proactive and continuous effort not to take notes or critically observe people who were attending the Show in their individuality; making an effort not to be visibly analysing all my

surroundings; and clearly disclosing my researcher status upfront to the organisations I talked to.

The ethical procedure of the study changed over the second and third year of the PhD programme. I conducted three pilot interviews in the second year with the HFEA, the NGO Progress Educational Trust, and a corporate head from the private clinic Care. These interviews are not part of the analysis, but contributed to my knowledge and awareness of the field. I soon realised that the material I needed was not obtainable through interviews, but rather through organisational documents. Consequently, the ethical approval of my work changed from the second to the third and fourth year.

With respect to observation, field research is a contested terrain where field relations can be understood in discursive terms. The field researcher both constructs and is constructed by discourses that they themselves embody and enact (McLaren, 1991). These reflections were very important to consider during my fieldwork, but they also represented a big challenge in terms of empathising without acting on behalf. Attending the Fertility Show but not being a prospective patient, a mother-to-be, or a mother, meant that my view and perception of a lot of issues were inevitably biased and different from the people the Show was originally meant for. McLaren stresses the importance of "feeling the everyday experiences of subjects" (1991: 154). However, trying to feel what others around us feel still does not represent full co-construction, but in turn positions researchers in a privileged position with respect to the researched. To help with this dilemma, feminist ethnographers suggest thinking of the question "in whose interests?" (Skeggs, 2001: 437) as a constant reminder of the power we produce and simultaneously are subject to. I tried to keep this question in mind during my fieldwork, and yet I found

that the answer was really available to me only after carrying out data analysis.

4.8. Data Collection and Selection

Data were gathered by attending the Fertility Show in 2013 and 2014. The Show is an annual event held in London "created solely for people…who need information and advice on their fertility" (The Fertility Show, 2014). It is an event where clinics, NGOs, lawyers, and other organisations involved in fertility treatment, information, and support meet people who are trying to conceive. Around 50 seminars are given by experts, with topics ranging from explanations of infertility and available treatments, to support, adoption, and alternative health approaches. Overall, the Fertility Show's aim is to provide prospective patients with all the information they might need before, during, and after treatment. Despite being fully open to the public, the nature of the event is highly confidential; as the website warns, their "strict privacy policy includes no photography, no press, not disclosing visitor details to anyone and no name badges" (The Fertility Show, 2014).

Fertility treatment and the Fertility Show in particular provide an illuminating setting when analysing organisations and bodies: not only do the organisations taking part at the Show physically intervene in existing bodies in order to create new ones, but at that event, at a specific time and in a specific place, such organisations present the texts they produce to the people who are meant to be the text consumers. I view this as a particular setting: at the Show, discourse takes place in a context where fertility issues are presented as accepted and not as taboo, unlike many messages we get from society which would suggest otherwise (see Franklin, 1990; Whiteford and Gonzalez, 1995; Thorn, 2009; Becker and Nachtigall, 1992).

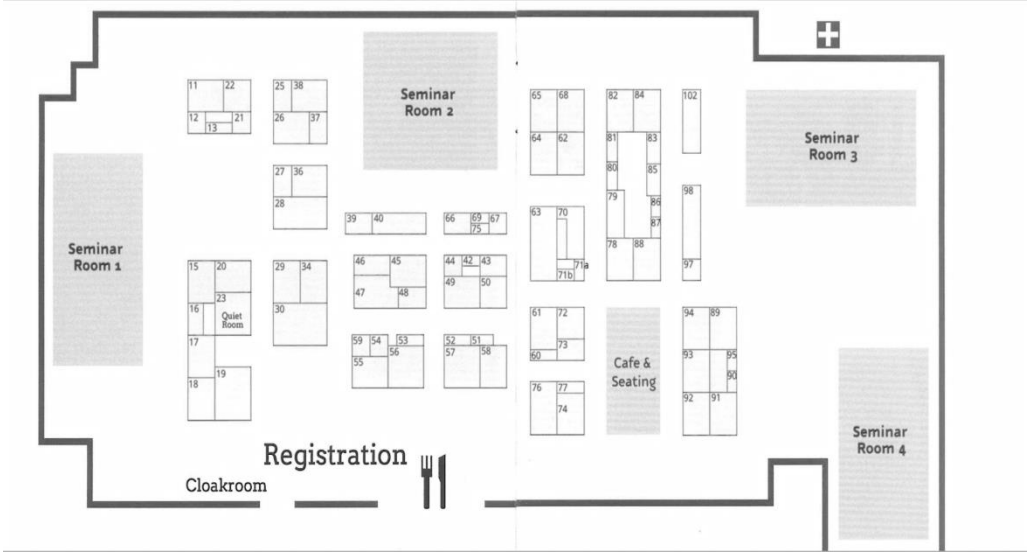
Instead, at the event the single woman, the lesbian couple, and the infertile couple can all meet and talk to the 'experts' and the organisations who make fertility issues their business, literally or figuratively. This is important with regards to field configuration, in that fertility treatment is configured through discourses employed during an event that inherently 'breaks' the taboo of infertility. Such practice is necessary for the FCE to take place. Outside of the Show, similar interactions would normally happen in the private setting of a private clinic, the office of a counsellor, or perhaps through private exchanges of phone calls and emails. Despite the caring and informal tone of the experts at the Show, which assumes an acceptance of the sensitivity of the topic, prospective patients interact with experts in a setting that is public. This is done, for instance, whenever a prospective patient in the audience publicly asks a question after the delivery of a seminar by a counsellor. Infertility might still be a taboo, but at the Fertility Show this taboo is shared and, particularly during and after the seminars, openly talked about.

Further, the Fertility Show takes place in a specific location and during a specific time of the year, at the end of National Fertility Awareness Week. The event lasts two days and takes place in a public venue that is often used for fairs and exhibitions. As mentioned earlier, the event hosts around 80 exhibitors including private clinics, NGOs, governmental bodies, and other businesses involved in fertility treatment. Seminars are given by doctors, counsellors, advocates, and NGOs, and take place in four locations in the same room where the exhibitors' stands are (see Figure 1 below). The topics focus on infertility and include titles such as "The Basics. What you need to know to get pregnant and how to prepare for pregnancy", "A beginner's guide to the fertility rollercoaster – what to expect",

or “The Top Ten ways to cope with infertility”. Attendance at the seminars needs to be booked online prior buying the tickets for the Show.

As I entered the room for the first time in November 2013, I realised that the atmosphere was indeed one that I had previously found in business and industry fairs. I found myself navigating a maze of stands, exhibitors, leaflets, and gadgets that had to do with a varied range of fertility-related products and services: from private clinics’ services, governmental informational material, and professional associations, to vitamins and supplements, yoga classes, and specialists offering astrological predictions of fertile dates. These organisations engage with prospective patients by answering their questions, offering information and suggestions and in some cases some initial treatment or a taster of their products, as in the case of vitamin supplements and fertility massages being offered freely at the Show. The exhibiting organisations also present prospective patients with a selection of gadgets, such as pedometers, pens, water bottles, tote bags, and key rings to name a few.

Figure 1. Map of the 2014 Fertility Show



Map of the 2014 Fertility Show: each numbered square represents an organisation exhibiting at the event.

For ethical reasons, I decided not to have any interactions with prospective patients, or with anyone who was not an exhibitor at the Show. In order to access the event, tickets had to be booked online and presented at the entrance, but no identification was required (as, for instance, a prospective patient or a health professional). I talked and interacted with different exhibitors from NGOs, regulators, and private businesses, and always disclosed my researcher status upfront. I did interact with some organisations at the Show, but never with prospective patients. I did sit at various seminars and took notes about them, and I did browse the various stands too – just like a prospective patient would do. At the same time however, the nature of my interactions with the exhibitors was exclusively research-bound, and my presence did not directly or overtly impact the dynamic of the event.

4.8.1. Data Selection

Data selection was divided into the following stages in relation to each research question:

Table 6. Research Questions and Selected Data for Analysis

Research Question	Selected Data for Analysis
a. How do organisations discursively construct the female non-reproductive body?	170 documents from 46 organisations exhibiting at the Show, later reduced to 21 (text analysis)
b. What relations are discursively constructed between the organisations at the Show and the constructed bodies?	Focus on 5 types of texts produced by 5 organisations (discourse practice)
c. How are these bodies and relations maintaining field legitimacy at the FCE?	Analysis and research outcomes from questions a. and b. (social practice) Secondary data, including: publicly available books, journal papers, and articles on the history of birth control and its political and social context until the development of IVF (prior to field emergence). Also, publicly available journal papers, books, and newspaper articles on the history and development of fertility treatment in the UK (prior to field emergence).

Specifically:

a. The construction of bodies and relations at the FCE level is examined by analysing discourses organisations employ at the Fertility Show. While attending the Show, I collected a large quantity of documents from a variety of exhibitors, and then reduced the amount of data for analysis to 21 organisations and 138 documents for text analysis, and to five organisations for in depth discourse analysis. These include governmental organisations, private clinics, professional associations, and NGOs (Appendix I). They were selected by virtue of their presence at the Show: the organisations were physically occupying more space at the event, were giving seminars on specifically technical information about fertility treatment, or had their stands at particularly central locations in the room. The analysed data entails leaflets, booklets, and seminar notes. All the documents were scanned and analysed using the qualitative data analysis software NVivo. The initial data sample comprised of 46 organisations and a total of 170 collected documents, including seminar observations. Because of the level of in-depth analysis required by my approach to CDA, I then limited the analysis to 21 organisations for text analysis and five organisations for discourse practice.
b. The five organisations selected for discourse practice analysis (research question 2) include one professional association; one private clinic; one NGO; one governmental organisation; and one media business. The media business Fertility Road was selected in representation of fertility-related businesses because of its relevance and peculiarity in the context of the event:

the magazine Fertility Road was handed to me whilst I was walking by the various stands. Reading the content, I realised that this type of document had a lot to tell to prospective and current patients about how to feel, think, and what to do about fertility issues and treatment. Esterberg notes how media accounts "are useful for understanding how groups of people are represented in public discourse or what norms and ideals for behaviour exist in a particular time and place" (2002: 124). For these reasons, an issue of the magazine was included in the analysis. The five organisations were selected for discourse practice analysis for the following reasons: 1) their presence at both the 2013 and 2014 Show; 2) their involvement in the delivery of seminars (government, NGO, professional association, and private clinic in particular); 3) their relevance in the field of fertility treatment (government, professional association, NGO); their reach to the public attending the Show (government, NGO, media business). All the organisations had stands during the Fertility Show in 2013 and 2014. Further details on the five selected organisations are presented in section 4.9.2.

c. Field notes were also taken at the Show (see Appendix III for the list of field notes and a sample). I employ them in the second level of analysis (discourse practice, chapter 6) to further contextualise and illustrate how organisations construct relations between themselves and the female body (research question 2).
d. It is worth noticing how the majority of the exhibitors at the Show are private actors: specifically, in 2013 62 out of the 78 exhibitors were private clinics or other businesses, whereas in 2014 66 out of the 82 exhibitors

were private clinics or other businesses. Indeed, the profit-driven nature of the majority of the organisations within the field takes various forms at the Show: from the presence of pricelists in clinics' and other businesses' booklets and offers of '3 IVF cycles for the price of 2', to gadgets and discounts being offered by a number of exhibiting organisations.

e. Social practice examines why certain discourses (emerging from text analysis) and relations (emerging in discourse practice) have come to be utilised by organisations at the FCE to maintain field legitimacy. Social practice brings together the first two levels of analysis and simultaneously links them to the concept of legitimacy presented in section 2.2. This level of analysis thus relates the discourses and relations emerging in text analysis and discourse practice so as to understand how organisations taking part at FCEs discursively maintain legitimacy. The documents employed to contextualise and integrate the research outcomes from text analysis and discourse practice were selected by virtue of being historical accounts of the social and political developments of reproductive medicine and rights in the UK, which in turn led to and legitimised the emergence of the field in 1978 with the birth of the first IVF baby. I further explain social practice in section 4.9.3.

4.9. Analytical Framework

As presented in sections 4.6 and 4.8, I employ CDA to answer my research questions. In this regard, Fairclough provides a three-dimensional analytical framework entailing a textual level, a discourse practice level, and a social practice level. I particularly refer to the model he proposes in his books

Language and Power (1989/2001) and *Discourse and Social Change* (1992), where he provides ample discussions of how power relations can be analysed through discourse. The next sections present definitions of key terms used in analysis and how the three levels of analysis are operationalised. Specifically, the definitions of the terms employed are provided under the relevant level of analysis.

4.9.1. Levels of Coding and Text Analysis

The aim of my text analysis is to investigate what types of bodies organisations at the Fertility Show construct in the texts they deliver to prospective patients. Text analysis represents the first step I take when approaching the data, and entails the completion of three levels of coding before moving to the next level of analysis (discourse practice). Fairclough's approach to text analysis is particularly used in the first level of coding, where I look at the words that are used in relation to the female body. At this level, I am interested in finding out the main terms and images related to the body, and their frequency. It is a deductive process, in that I decided to look at how the body is being described in relation to the physical body, to the concept of gender, of family, and of the patient. I therefore explicitly looked for words in relation to these four concepts in the texts. This was done because fertility treatment explicitly acts on a physical body that is gendered (female body and/or body of a woman) and that aims to create or complete a family through medical procedures (thus by being a patient). I identify micro-categories related to the body that I then group in broader macro-categories. At the second level of coding I re-group the categories emerging in the first level into common themes. Here the categories are interpreted and positioned together with other categories that convey a similar understanding of the

body. At the third level of coding I interpret the thematic categories emerging at the previous level and further organise them into a number of main discourses of the body. These discourses will be the starting point for my analysis of discourse practice (see section 4.9.2). Macro-categories do not automatically become thematic groups, but become so depending on the frequency and the similarity of interpretation of the inductive micro-categories. The coding process pre- and post-analysis can be found in Appendix II.

Table 7. Orders of Coding (Pre-Analysis)

1st order of coding ***Discursive Constructions: Concepts and frequency***	**2nd order of coding** ***Discursive Constructions: Common themes and frequency***	**3rd order of coding** ***Discourses of the Body***
Words used in relation to the body in its physical, gendered, familial, and patient features.	*Frequency, similarity, interpretation of categories.*	*Themes' similarity, frequency, and interpretation.*
Deductive macro categories of the body: Macro category #1 - Inductive micro categories Macro category #2 - Inductive micro categories Macro category #3 - Inductive micro categories	*Thematic group 1* Discursive Construction A Discursive Construction B Discursive Construction C *Thematic group 2* Discursive Construction A Discursive Construction B Discursive Construction C	*Discourse 1* Body A *Discourse 2* Body B *Discourse 3* Body C

	Thematic group 3 Discursive Construction A Discursive Construction B Discursive Construction C	

Adapted from Gioia et al., 2012.

When undertaking the first level of coding I examine a number of elements in the text based on Fairclough's work (1989/2001; 1992). Such analysis allows for the identification of discourses of the body organisations employ at the FCE. In this regards, a *text* is "the written or spoken language produced in a discursive event" (Fairclough, 1995a: 135). A key element when *analysing texts* relates to paying attention to textual structures (such as verbs, adjectives, subjects, etcetera) that can be found in the text, but also to text meaning and wording. Specifically, the elements I choose to analyse in the text are some elements of grammar, and key words.

In my analysis, grammar includes *transitivity*, which entails the analysis of "the types of participant involved" in the sentence (Fairclough, 1992: 178). Here I look for *agents and goals*, and the voice used in the clause. Transitivity further includes the analysis of *key words* and *word meaning,* but also of *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: 179). I further look at pictures representing the female non-reproductive body within the selected organisational texts.

In sum, the outcome of text analysis is the identification of:

1. Discourses of the body, through the three orders of coding presented in Table 7.
2. The analysis of transitivity, which includes: a) the types of participants, agents and goals; b) key words and word meaning; c) nominalisations; and d) pictures representing the identified discourses.

4.9.2. Discourse Practice

Discourse practice is employed to answer the second research question, and is thus concerned with investigating what relations organisations at the Show construct between themselves and the bodies emerging from text analysis. Specifically, discourse practice has to do with "processes of text production, distribution, and consumption" (Fairclough, 1992: 78), and is an interpretative, analytical step. It can also represent an indirect link between the text level of analysis and the social practice one (Fairclough, 1995b: 60; 1989/2001).

This second level of analysis has to do with the concept of intertextuality, which refers to "how texts can transform prior texts and restructure existing conventions (genres, discourses) to generate new ones" (Fairclough, 1992: 103). Thus the texts examined in text analysis can be employed by actors to reorganise existing discourses, or to create new ones.

To be clear, discourse practice can be analytically applied in different ways: in a text I can explicitly look for elements from other pre-existing texts by, for instance, looking at references or citations; or I can look at how certain discourses are used to build relations. I here use the latter approach, and examine how the discourses of the body emerging in text analysis are used by organisations to construct relations. This is particularly important as to understanding how organisations use the discourses they draw upon to maintain legitimacy. By

using certain discourses of the body, organisations might construct themselves in different relations to the body depending on the legitimacy they might want to maintain in relation to the female non-reproductive body.

Within organisation studies concerned with the critical analysis of discourse, so far scholars following Fairclough's approach to CDA have implemented his three-level framework (text analysis, discourse practice, social practice) very similarly; in their analyses, they particularly conceive intertextuality as the relations between different physical texts and mostly examine references and citations. In this thesis, I follow a second interpretation of intertextuality: while still connecting the text to pre-existing discourses, I remain within the same text and look for relations between text producers and text consumers that have been created through the pre-existing discourses emerging from that same text. In brief, the pre-existing discourses which I use to analyse discourse practice are the ones emerging from the text analysis of the same text.

I hold that this interpretation of discourse practice, which to my knowledge is seldom found within organisation studies concerned with CDA, is valuable to organisation scholars interested in critical aspects of discourse particularly with regards to issues of power, because it allows for imbalanced relations of power to *explicitly* emerge between the text producer and the text consumer. This, in turn, shows us those power relations that CDA notoriously aims to unveil and challenge. In sum, I think this interpretation of discourse practice makes *power* more visible because it makes *relations* very visible, before proceeding to contextualise them socially, historically, and/or politically (at the social practice level of analysis).

Building on text analysis, at the discourse practice level I analyse texts from five organisations where the discourses emerged. Then, I analyse intertextuality within those texts to understand what relations such discourses engender. As mentioned before, this part of the analysis focuses on five organisations attending the Show: one per each type of exhibiting organisation. This level of analysis includes entire texts or sets of texts.

***Table 8. Selected Organisations and Texts for Discourse Practice Analysis*.**

Organisation	Text
Government *HFEA*	Booklet *Getting started. Your guide to fertility treatment*.
Private Clinic *The Fertility and Gynaecology Academy*	Booklet *Brochure 2014*
NGO *Infertility Network UK*	Magazine Issue *Autumn 2014 n. 43*
Professional Association *UK Professional Fertility Societies*	Set of 18 leaflets *Various topics (counselling, fertility-related conditions)*
Other Business - magazine *Fertility Road*	Fertility Road Issue *Issue 23 Nov/Dec 2014*

Because this level focuses on organisations and power relations, I refer to Fairclough's *Language and Power* (1989/2001) for my analysis. Here, the author stresses how "power in discourse is to do with powerful participants controlling and *constraining the contributions of non-powerful participants*." (1989/2001: 38). These constraints take place in three ways: through contents ("what is said or done", which is the focus of text analysis), relations ("the social relations people enter into discourse"), and subjects ("the 'subject positions' people can occupy") (Fairclough, 1989/2001: 39). All three are tightly connected, and in practice they co-exist and co-occur.

My focus here is on organisations as text producers, and on how they construct the text consumers' subject positions. Therefore, I approach discourse practice keeping these three constraints in mind: having examined how contents construct subjects (through the discourses of the body emerging from text analysis), this second level of analysis focuses on relations and subjects and aims to understand how organisations use the discourses they construct (contents) to create relations and position subjects (relations and subjects).

There are three guiding questions I answer when carrying out discourse practice analysis, namely:

- *What's going on?* This includes taking into account the activity type and topic in the text (Fairclough, 1989/2001: 123);
- *Who's involved?* Here I look for the subjects involved in the activity type, which can vary depending on the activity that is being described.
- *In what relations?* This is where *what's going on* and *who's involved* are examined together to understand how they relate with each other through the text.

These questions are answered through intertextuality, which in turn entails the analysis of *modality* and *presuppositions*. These two features allow me to identify subject positions, which are the positions of organisations and of the prospective patients attending the FCE. Specifically, the analytical question I answer is the following:

Through the texts they produce, how do organisations at the Fertility Show construct their own subject position and that of the prospective patient?

Subject positions are thus constructed through text (how they construct the body) and intertextual context (how they employ constructions of the body to construct relations between themselves and the prospective patient). To do so, organisations *presuppose* the subjects will be positioned in a certain way, based on the discursive constructions identified in the first level of analysis (text analysis). However, these discursive constructions are placed in an intertextual context: they are linked to previous texts and this link can be seen by looking at formal features in language related to *modality* (subjective/objective, use of auxiliaries) and *presuppositions* (negative sentences and negations, emphatic assertions, etc.).

In this regard, Fairclough specifies that: 1) because discourse and text happen in history, their interpretation requires the researcher to understand what participants share as 'common ground' in such a historical context, and is thus presupposed; that 2) presuppositions might be imposed by more powerful participants upon less powerful ones; and that 3) by doing so, powerful participants can decide what in the historical context of discourse is to be taken as common ground by all participants, thus presupposed (Fairclough, 1989/2001: 127). In this sense, discourse practice can never really be sealed off from social practice, or text analysis. Nonetheless, the three levels are here distinguished and examined separately for analytical purposes.

As mentioned above, when analysing discourse practice, I specifically focus on modality and presuppositions. *Modality* refers to the interpersonal function of language and has to do with the extent to which text producers create distance from or commit themselves to propositions (Fairclough, 1992: 142). It is associated with modal auxiliary verbs such as 'must', 'may',

'can', 'should' and adverbs such as 'probably', 'possibly', obviously', 'definitely'. Modality can be *subjective* (for example "I think fertility treatment is a good choice") or *objective* ("fertility treatment may be a good choice").

Conversely, *presuppositions* are not properties of text, but are instead the text producers' interpretations of the intertextual context. However, they are "cued in texts" and can be identified in the text by looking at formal features (Fairclough, 1989/2001: 127). Presuppositions are important because through them, the text producer assumes that what they are saying in their texts is "to be found in antecedent texts that are within readers' experience" (1989/2001: 128). This means that organisations at the FCE will understand that their assumptions are common ground between themselves and the prospective patients.

I identify presuppositions through links to prior texts produced by others or by the text producer. An example of presupposition can be found in the following sentence on Intra-Uterine Insemination (IUI) extracted from a private clinic booklet: "This painless procedure is among the least invasive treatments". Here we can notice two presuppositions: 1) that the prospective patient will hold a certain level of concern with regards to undergoing painful procedures, as well as a level of knowledge with regards to other fertility procedures which are, unlike IUI, painful; and 2) similarly, the invasiveness of the procedure is pre-supposed to be a matter of concern which the prospective patient is assumed to have encountered when reading of or attempting other forms of treatments.

I also identify whether the presuppositions are sincere, manipulative, or negatively phrased (polemical). When text producers' presuppositions are manipulative or polemical, they

are also difficult to challenge. In the example I provided above, the presuppositions are partly sincere and partly manipulative: I see them as sincere in that pain and invasiveness are legitimate concerns any prospective patient might have when it comes to medical procedures. But I also see them as manipulative, in that regardless of the comparison with other forms of fertility treatment, IUI is *still* an invasive procedure.

At the intertextual level, through presuppositions text producers can make resistance difficult to carry out by text consumers: they can position text consumers as already having an experience of the text, which is often difficult to realise and therefore challenge (Fairclough, 1989/2001). In sum, by analysing discourse practice I aim at showing how organisations position themselves through the use of the discourses of the body identified through text analysis. This positioning is analysed by looking at modality and presuppositions.

Table 9. Elements of Discourse Practice.

Intertextuality						
Modality			*Presupposition*			
Subjective	Objective	Auxiliaries used	Cues in text	Sincere	Manipulative	Polemical

4.9.3. Social Practice

Once the discourses of the female non-reproductive body have emerged (text analysis) and the relations in place between organisations and prospective patients have been identified (discourse practice), the research outcomes are linked to the social practice level of analysis. The aim is to answer the third research question, and thus examine how the discourses and

relations emerging in text analysis and discourse practice are employed at the FCE to maintain legitimacy.

In this regard, I understand language as socially conditioned, which means that what we say is influenced by the social context we live in. Language and society do not exist separately, but co-exist in a way that makes social phenomena to be at least in part linguistic phenomena, and vice versa. In this regard, discourse reproduces social structures while simultaneously being determined by them (Fairclough, 1989/2001).

The social practice level relates the discourses and relations emerging at the FCE to the broader social context where legitimacy needs to be maintained with respect to an organisational field that necessarily acts onto the female non-reproductive body. The aim is to unveil how organisational discourses and relations shape or reproduce social structures on the female non-reproductive in order to maintain field legitimacy.

In the analysis, I carry out social practice by historically contextualising the discourses and relations *before* field emergence, so as to understand *how and why* they are being employed today at the FCE to maintain legitimacy.

4.10. Plausibility, Validity, and Reliability of the Research

The concepts of objectivity and validity traditionally employed in quantitative research need to be modified when carrying out CDA (Wodak and Meyer, 2009). This has to do with the approach to conventional scientific knowledge adopted by CDA. Particularly when analysing discourse, both social constructionism and CDA criticise the notion of objectivity and the means of production of conventional knowledge, and view the researcher's bias as inevitably embedded in the research

process (Wodak and Meyer, 2009). The precondition of discourse is in fact the existence of a reality which is socially constructed, and where unequal relations of power take place. Instead, what CDA is concerned with is processes of knowledge production, which is where the analyst's work should contribute (Weiss and Wodak, 2003).

However, making sure that our work is plausible, valid and transferable within CDA is nonetheless paramount. Plausibility refers to the researcher's ability to "convince the reader of the soundness and sense of their research" (MacPherson, 2008:187). This can be achieved through strong descriptions (Silverman, 2010) and transparency (Gephart, 2004). CDA brought me to produce thick descriptions of the data, particularly during the level of text analysis, which is descriptive by nature. I achieved transparency by regularly producing tables and step-by-step analytical frameworks and analysis samples, which also provided my supervisors with the tools to verify my analytical process.

DA suggests completeness as a criterion for validity: when applied to the purpose of CDA, a complete analysis includes "careful systematic analysis, self-reflection at every point of one's research and distance from the data which are being investigated" (Wodak and Meyer, 2009: 33). This approach to validity poses a clear challenge related to self-reflection and the approach to data. Fairclough (2001/1989) uses the term Members' Resources (MR) to refer to the cultural and social resources drawn upon by analysts, and stresses the importance of critical self-reflection throughout the research process. Reflecting on my preconceptions, biases, and cultural and social background becomes a necessary practice in order to maintain the critical and political features of CDA. This was achieved by

trying to be reflexive at every step of the research process, but also through insightful interactions and discussions with my supervisors and fellow academics and practitioners at various conferences. I discuss this in more detail in section 4.12.

As the various constructions emerged, I began to analyse them and make sense of them: this step often included discussing the emerging 'findings' with my supervisors, discussions which lead to reformulating questions and constructions, or simply to more politically-aware conceptualisations - where by political I refer to power relations between the knowledge producer (myself) and the data used to produce such knowledge. This back-and-forth process (that of description and interpretation followed by discussion with the supervisors, and vice versa) took place at various moments during data analysis. I think these regular interactions contributed to a more self-reflective and open approach to my data and my research as a whole.

There are further points to consider to ensure that the research is addressing issues of validity and reliability. Following Morse et al (2002), these have to do with the verifiability of the research. The authors specifically mention that the researcher should ensure her study is verifiable through practices such as "ensuring methodological coherence, sampling sufficiency, developing a dynamic relationship between sampling, data collection and analysis, thinking theoretically, and theory development" (Morse et al, 2002: 18). Ensuring methodological coherence entails the alignment of the research questions with the chosen methods. This has been ensured by keeping my research questions open to change as my analytical framework evolved. Sample saturation "ensures replication in categories; replication verifies, and ensures comprehension and completeness" (Morse et al, 2002: 18). My

data sample saturated as I progressed with data analysis, and noticed replication of emerging topics and discourses. Thinking theoretically refers to when "[i]deas emerging from data are reconfirmed in new data; this gives rise to new ideas that, in turn, must be verified in data already collected" (Morse et al, 2002: 18). I link this to data saturation, in that the emergence and repetition of discursive constructions was confirmed at later stages of the iterative process of data analysis. Finally, theory development ensures the movement from the micro level of data to the macro level of theory. This takes place throughout analysis, but more explicitly comes together at the stage of discussion when the research contributions are clarified.

4.11. Critiques and Limitations of a CDA Approach

CDA can be a challenging approach to data analysis and indeed has its limitations, for which it has been subject to criticism. Billig identifies the weakness of CDA in its aim of producing a critique of society through analysis, arguing that such critique is instead "the raison d'etre for analysis" (Billig, 2003: 39). If CDA happens, then, it is because social critique is *already* taking place before any analysis is conducted. Further, CDA has been accused of vagueness when defining its analytical concepts, methodologies, and tools, and of clouding important distinctions between these (Widdowson, 1995; 1998). CDA's conceptual richness is regarded as a sign of a lack of specificity which in turn becomes problematic during operationalisation: how are CDA researchers *de facto* meant to carry out analysis? Overall, the blurriness and eclecticism of CDA, whilst being considered a great sign of interdisciplinary dynamism by its scholars (Weiss and Wodak, 2003) is seen by critics as a problematic feature of the CDA school (Schegloff, 1997). Infusing research with political beliefs and bias has also been

seen as imposing a certain ideological reading of the text upon the reader. Pennycook (1994) further criticises CDA for utilising deterministic and reductionist frameworks, but notes how the use of a Foucauldian approach to discourse might help move beyond these issues.

Despite these criticisms, CDA provides strong insights on how unequal power distributions in society take place in a way other approaches to discourse analysis do not. As per the issue of vagueness and cloudiness of terms, what is missing in CDA is not clarity of terms, but rather a fixed common set of meanings. In fact, CDA scholars stress the importance of the constant need of redefining terms in relation to the culture, ideology, and political landscape the research is analysing. Thus, concepts are not cloudy at all; rather, they are required to be explicitly and clearly defined prior to each specific analysis. This forces the researcher to be highly specific and clear in relation to the concepts and assumptions she is drawing upon in her research. CDA is not vague and cloudy *per se*, but its contextuality requires openness when thinking of CDA as a broad analytical approach. CDA acknowledges the relativity of concepts and methods: setting a fixed methodology and fixed definitions would limit the scope of CDA, and would render it politically irrelevant.

As per the critique against infusing research with political beliefs, CDA requires the researcher to openly acknowledge her bias before the analysis takes place. The CDA researcher does research because she sees a problem in relation to unequal power distributions in society. A political position is not necessarily a bad trait of research: Bryman (2004) gives the example of feminist researchers requiring a political stance in their research. Feminist research is aimed at improving women's conditions, hence the researcher *has* to take a political

position in favour of the feminist struggle in order for her research to advance women's rights. CDA acknowledges research as inherently political specifically because of this necessary, inevitable, and accepted bias. Being neutral and apolitical would not be regarded as appropriate when trying to unveil relationships of power imbalance and oppression – it would instead contribute to perpetuating such power inequalities. In this sense, the political foundation of CDA can be linked to broader critiques against the idea of objectivity and absence of bias when carrying out qualitative research. Thus the use of CDA makes a strong point in favour of transparency on the researcher's side when conducting research.

4.12. Reflexivity

Being reflexive when carrying out qualitative research can refer to a variety of practices, including questioning the context of knowledge production, investigating the relation between the research and the researched, and developing "alternative viewpoints and vocabularies" as a way of being critical towards our own position and perspective (Alvesson and Ashcraft, 2010: 72). Additionally, positionality can be carried out

> "wherein researchers relate emotional dimensions of knowing… and weigh their participation in the politics of research…Of equal importance, it entails the researcher's openness to receiving and absorbing as well as delivering challenge." (Alvesson and Ashcraft, 2010: 73)

The emotional dimension of fertility treatment and the emotional component I could feel at the Fertility Show were important aspects of the research process. Being a woman of fertile age not personally involved in the process of conception

or donation brought me to experience a level of empathy throughout the fieldwork that I had not expected to reach. Of course, I have had the occasional relative asking me when I would 'finally' decide to find a partner and have children. But apart from those brief and relatively unimportant remarks, I had never confronted the emotional pain of infertility. This empathy came with time, reflection, and experience. When I first ventured into the Fertility Show in November 2013, I left at midday instead of 4pm, which was when the Show was meant to finish on that day. I was not being lazy or superficial in my data collection: I just *could not stay there* any longer. It had become emotionally unbearable. In a way, I felt what I was experiencing was close to a sensorial and emotional overload: walking through the narrow pathways in between stands, I was handed leaflets, booklets, and gadgets. I was being approached and kindly smiled at. At the same time, the people around me were moving around not quickly, but with a sense of urgency nonetheless. It was not just a matter of time, but rather of careful selection and information gathering. In November 2014, I felt mentally and emotionally prepared and ready. Nonetheless, while attending a seminar on the latest research, technologies, and treatments available, I suddenly felt extremely sad at the realisation of my position with regards to everyone else sitting around me. I was there, taking notes and thinking about my research problem, while the people around me attending the same seminar were possibly making strong and difficult life decisions.

Sanger notes that when the researcher observes, one issue they face "is that by merely being there, he/she highlights for everyone the political nature of both working and social life" (1996: 29). Was what I was experiencing only empathy, or had the politics of fertility treatment and infertility manifested to me

through the emotions and thoughts I was having at the Show? Was my being there legitimising, challenging, or reinforcing the initial power relations I had started to notice? As a researcher, how do I make sense of this? In her discussion of feminist ethnography, Skeggs suggests that the "[r]ecognition of the positioning and channels of power may be one way of not engaging in normalizing power relationships" (2001: 434). Thinking critically about who was in the position of *knowing* and *doing* was an effort I tried to make reflexively throughout data collection, analysis, and discussion.

My approach towards crucial feminist issues related to women's reproductive choice has typically been quite critical: having read and mostly embraced understandings of discourse and medical practice developed by critical theorists, I approached my data with a critical eye which I nonetheless tried to moderate. The position I instinctively took with regards to data and data analysis was inevitably influenced by the intense experience of data collection, and by the myriad of conflicting thoughts and feelings such experience generated in me. In this context, reflexivity was maintained through a constant effort toward self-awareness: as I read and analysed data I asked myself "Am I ascribing over-critical readings to this text, or is this actually what the data is telling me?". I cannot say that answering this question was always easy, and particularly because the method used is Fairclough's approach to CDA, my inherent bias is a feature of my analysis I will have to accept – but which I have nonetheless tried to minimise as much as possible.

4.13. Conclusion

In this chapter I have presented the philosophy, approach, and methods underpinning my research. I have discussed how

the thesis is ontologically and epistemologically informed by principles of social constructionism (4.2) and specified why I see both the body and organisations as products of social construction (4.2.1). I then proceeded to introduce the approach I take toward the analysis of discourse, differentiating the notion of Discourse Analysis (DA) from that of Critical Discourse Analysis (CDA). Here I stressed how CDA is not to be seen as part of DA, nor a particular method to analyse data: rather, CDA is characterised by the critical and political approach taken by the researcher as early as in the stage of research design and research problem identification (4.4). I further presented the main approaches to CDA, namely Van Dijk's, Wodak's, and Fairclough's, and explained why Fairclough's approach is the most suitable to answer my research questions (4.4 and 4.5).

The chapter continued to discuss the research design and the choice of the body and organisations involved in fertility treatment as a research problem (4.6), and moved on to present the methods used in the study, which entail document analysis and observation (4.7). I then presented data collection and selection for each research question (4.8), before introducing the CDA-informed analytical framework I use. This is comprised of three levels of analysis: textual analysis, discourse practice, and social practice. Within each level I identify a number of analytical units that will guide the analytical process. These are grammar features such as key words and word meaning, participants, and voice in textual analysis; modality and presuppositions, which constitute my approach to intertextuality, in discourse practice; and the social and historical context of discourse in social practice (4.9). Further, I discussed issues of validity and reliability

(4.10), the critiques and limitations of CDA (4.11), and how I applied reflexivity throughout my work (4.12).

The next chapters in the thesis are empirical, and present the results emerging from data analysis. Chapter 5 presents the results emerging from text analysis: here I identify discourses of the body employed by organisations at the Fertility Show, which in turn entail a number of discursive constructions of the female non-reproductive body found in the collected organisational documents. Chapter 6 presents the discourse practice analysis and shows how organisations employ the discourses of the body emerged in chapter 5 to construct relations between themselves and the female non-reproductive body. Chapter 7 presents the social practice level of analysis, and explains why and how the bodies and relations emerged in chapters 5 and 6 are employed by organisations at the FCE to maintain field legitimacy.

CHAPTER 5. TEXT ANALYSIS: CONSTRUCTING THE FEMALE NON-REPRODUCTIVE BODY

5.1. Introduction

In chapter 3, I showed the historical and social background underpinning the field of fertility treatment's emergence and development until the creation and success of a FCE, the Fertility Show. I further presented how pragmatic, moral, and cognitive legitimacy was obtained by the field. This chapter is concerned with the first of the three analytical steps I take to examine how field legitimacy is maintained at the FCE: text analysis, discourse practice, and social practice. I thus here present my text analysis, which aims at answering the following research question: *How do organisations discursively construct the female non-reproductive body?*

As mentioned, the focus is on how FCEs discursively maintain field legitimacy. The field's FCE is represented by the Fertility Show. The analysis shows that organisations attending the Show use specific discourses on the body to do so. Field legitimacy is here analysed by looking at two elements: 1) the discourses of the non-reproductive female body organisations employ at the Show, and 2) how such discourses are used by the same organisations to create relations between themselves and to the female non-reproductive body. This chapter is concerned with point 1) and thus presents the discourses and discursive constructions of the female non-reproductive body organisations employ at the Show. Such discourses are the result of text analysis within the CDA approach presented in chapter 4. Point 2) is examined through discourse practice in chapter 6, and shows how organisations use the emerging discourses to construct different relations between themselves and the female non-reproductive body at the FCE.

Specifically, in this chapter I introduce the analytical process I followed during text analysis (5.2), before presenting the discourses emerging from analysis. These are those of the medical body (5.3), the distressed body (5.4) and the cared for body (5.5). Each discourse is in turn comprised of a number of discursive constructions which are discussed in relation to the main discourse they pertain to, as well as to each other (5.6). Finally, section 5.7 concludes the chapter (5.7).

5.2. From Bodies to Discourses: Analytical Process of Text Analysis

Before presenting the emerging discourses of the body employed by organisations at the Fertility Show, I here explain how the three orders of coding presented in section 4.9.1 manifested during data analysis. This step is important because it shows how I moved from emerging concepts on the body to broader thematic groups before reaching the third order of coding – which is where the three discourses of the female non-reproductive body emerge. The process can be seen in the table below:

Table 10. Orders of Coding, Post-Analysis.

1st order of coding ***Discursive Constructions: Concepts and frequency***	**2nd order of coding** ***Discursive Constructions: Common themes and frequency***	**3rd order of coding** ***Discourses***
Words used in relation to the body in its physical, gendered, familial, and patient features.	*Frequency, similarity, interpretation of categories.*	*Themes' similarity, frequency, and interpretation.*
Disembodied Body - Animal - Dysfunctional - Examined - Fragmented - Personal *Gendered Body* - Awareness - Conflation - Neutrality - Normative body - Sex *Familial Body* - Emotional distress - Future life - Success and happiness *Patient Body* - Cared For - In Control - Helplessness - Self-care	<u>Thematic group 1</u> Animal Examined <u>Thematic group 2</u> Distressed Successful <u>Thematic group 3</u> Cared For Self-care In Control	<u>Discourse 1</u> Medical body <u>Discourse 2</u> Distressed body <u>Discourse 3</u> Cared for Body

Adapted from Gioia et al., 2012.

I have grouped the seventeen discursive constructions listed above into three discourses of the body, after following the three levels of coding presented above. As I described in section 4.9.1, at the first level of coding I looked for the main terms and images related to the body, and their frequency. I particularly decided to look at how the body is described in relation to the physical body, to the concept of gender, of family, and of the patient. I identified micro-categories related to the body that I later grouped in broader macro-categories. At the second level of coding I re-grouped the categories emerging in the first level into common themes. Here the categories are interpreted and positioned together with other categories that convey a similar understanding of the body. At the third level of coding, I interpreted the thematic categories emerging at the previous level and organised them into a number of main discourses of the body.

The three discourses are the medical body, the distressed body, and the cared for body. I began the second level of coding by reducing the seventeen inductive micro-categories to the ones more frequently emerging from data. The categories of fragmented body, personal body, future life, helplessness, and gendered body were either not included in the second order of coding, or were merged with the thematic groups in the second order of coding. Specifically: a) the dysfunctional body was coded in a similar fashion to the distressed body, and was thus incorporated into the latter; b) the fragmented body was coded similarly to the examined body, and was merged with it; the same goes for the personal and distressed body (c); for future life and success (d); and for helplessness and success (e). The constructions under the gendered body emerged in a much more sporadic way with respect to the discursive constructions

related to the disembodied body, the familial body, and the patient body, and will hence not be discussed in this chapter.

Each of the three discourses of the body (3rd order of coding) is comprised of two or three discursive constructions, respectively:

- The medical body is comprised of the animal body and the examined body;
- The distressed body is comprised of the distressed body and the successful body;
- The cared for body is comprised of the cared for body, the self-caring body, and the in-control body.

Thus for each discourse I here present the main constructions emerging in the second order of coding. I employ the distressed body and the cared for body as overarching terms also for lower levels of analysis (discursive constructions within the discourse). I made this decision because the two discourses engender dualistic discursive constructions that nonetheless depend upon the concepts of distress and receiving care. More specifically, within the discourse of the distressed body, both the discursive constructions of distress and success deal with the outcome of treatment. The body is consequently constructed in association with either a positive outcome (success that will remove distress) or a negative one, which in the data emerges as either failed treatment, the absence of treatment, or a situation of pre-treatment (which will cause distress). Within the discourse of the cared for body, the discursive constructions of cared for, self-caring, and in-control all entail an understanding of the prospective patient's body as something that is in need of care – either from the organisation,

or from the patient themselves. I identify and present these dynamics in more detail in sections 5.5.3 and 5.6.4.

In the next sections I present the content of the analysed texts, the three discourses of the body, and the emergence of the discursive constructions within each discourse.

5.3. Content of Analysed Texts

This section is concerned with introducing the content of the main texts I have examined in this level of analysis. I divide them on the basis of the organisation that produces them.

a. *HFEA*. The main text analysed is the booklet *"Getting started. Your guide to fertility"*, which was distributed to prospective patients at the Show. The booklet contains sections on what steps to take to improve one's health in relation to fertility; what fertility treatment entails, the techniques, technologies and drugs that are currently available; suggestions on how to choose clinics; and how to find support and counselling.
b. *Private clinics*. These organisations primarily distributed booklets and leaflets at the Show. These documents usually included a presentation of their medical directors in the first pages, and proceeded to present infertility and fertility treatment; their rates of success; and the services and treatments they offer. In some cases, a final section with a price list was included. Overall, because of the similar aim shared by private clinics, the content of their booklets and leaflets did not significantly vary from one clinic to another.
c. *Professional Associations*. Within the field of fertility treatment, I have mentioned how most professional associations are represented by the overarching association called *UK Professional Fertility Societies*

(chapter 3). The association produces a large number of small leaflets containing technical and medical information about fertility conditions, treatments, choices, and counselling. Some leaflets dealt with very practical issues, such as for instance how to deal with specific feelings related to infertility, or how to correctly produce, store, and submit semen samples to the clinic.

d. *NGOs*. The texts produced by NGOs attending the Show were largely coming from IN UK, due to its important presence and influence at the event. I particularly collected and analysed its most substantial texts, which are four issues of their magazine. The content is varied, but consistently so: the issues all contain a presentation of the NGO's corporate partners and an introduction written by the NGO's director. The text contains letters and articles from volunteers with regards to their experience of infertility, treatment, or volunteering; articles written by members of other infertility-related NGOs, or by the HFEA; and articles publicising particular events or meetings.
e. *Other businesses*. Texts produced by other fertility-related businesses are varied, and include those of a media business (the magazine Fertility Road), and leaflets from various service providers, from astrology businesses to legal services and vitamin and supplement providers. With the exception of Fertility Road, documents produced by these businesses all present the product or services aimed at the public. There tends to be a generous use of previous customers' testimonials expressing how the business helped them 'fulfil their dream' of creating a family, particularly when regarding health- and nutrition-related businesses. The

magazine Fertility Road is in this regard different, in that by its nature it contains a variety of articles on nutrition, health, difficult feelings related to infertility, success stories, treatments, and a variety of approaches to infertility (from stress management to meditation). It further contains a high number of advertisements, often included within articles on other fertility-related topics.

5.4. Discourse of the Medical Body

The discursive constructions of the animal body and the examined body construct the discourse of the medical body. These discursive constructions understand the body as an object of the medical gaze, whether by virtue of its animal feature, or of its being an object of science to be healed, examined, or modified.

Discursively constructing a body that is animal suggests a reductive approach primarily focused on the body's biological terms. Because the body involved in fertility treatment is understood as animal (not specifically human or humane), the cause of present or potential fertility issues is located in biology rather than in the person and their lived experience.

A body that is constructed as examined implies the justification of forms of intervention on the body through ever-newer tests, drugs, and technologies. If the prospective patient's body exists to be examined, how much of them can be tested? Fertility treatment entails numerous small steps to be taken by the patient (initial checks, screens, tests, examinations) throughout the process. This leads to an organisational understanding of infertility as a partial experience, always separable and testable; it further excludes discussions about the environment and context where infertility is experienced and lived. When has a body been examined

enough? In the following sections I present these discursive constructions in detail.

5.4.1. The Animal Body

The animal body refers to a body that is understood primarily in its biological and animal terms. Words like *'assisted egg hatching*' and descriptions of certain treatments might as well be read as if coming from an animal studies book. Here, the prospective patient's body is understood in its primordial animal features rather than human. The 'human' dimension in reproduction is, in this case, not taken for granted, but rather surpassed, moved beyond, and ultimately ignored. This will be explained later in this section.

Examples of the emergence of the discursive construction of the medical body in the texts include:

1. 'just *before the eggs are harvested'* (other business, Fertility Road magazine)
2. '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)
3. '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)
4. 'Two *embryos were put back* in and *one is still with us*' (Other business, leaflet – customer's description of their experience with treatment)

These examples show a use of body parts in the text that does not refer to human body parts specifically or explicitly; indeed, the same sentences could be applied to animal

reproduction. See for example the table and quotes below, which are excerpts from Gordon's book *Controlled Reproduction in Cattle and Buffaloes* (1996):

Figure 2. Excerpt from Book on Animal Reproduction

Table 8.4. Results of large-scale trial on twinning by one-embryo transfer conducted in the former Czech Republic. Data from Riha and Petelikova (1990).

Mean no. of eggs recovered per superovulated donor	12.08
Average no. of embryos recovered per donor	9.32
Embryos as % of all eggs recovered	70.4%
Average no. of transferable embryos per donor	4.81
No. of transfers carried out	7185
No. pregnant to first service	4124
Conception rate in recipients	57.4%

from Gordon (1996: 385).

- "It is believed that the sperm reservoir could serve to reduce the risk of polyspermy while ensuring that *sufficient sperm are available in the oviduct when ovulation does occur*; it may also provide a favourable microenvironment for sperm survival" (Gordon, 1996: 13).
- "Before it reaches the *blastocyst 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" (Gordon, 1996: 16).

Here, too, we can see a use of body parts in the text that does not refer to human body parts explicitly, and indeed the excerpts above refer to body parts of cattle. We can see how the words used to refer to the human body undergoing

treatment are similar (if not the same) to the ones used to describe bodies of animals undergoing treatment in animal farming. This in turn highlights an understanding of the human body undergoing treatment as animal. Whereas the process of fertilisation can be argued to be very similar, the environment, justification, and context are instead very different: whereas cattle is bred in farms and mostly to sustain the food industry, within fertility treatment the woman is fertilised in a clinic for social purposes related to motherhood.

Amongst the analysed organisational texts, there are 538 references to the animal body. Its emergence is more frequent within texts produced by professional associations (174), private clinics (155), and the government (120). Examples of key words used to construct the animal body are words that can and are used also to describe animal body parts: sperm, eggs, embryo, fertilisation, to harvest. The form mostly used is passive. The animal body also emerged through pictures. Below is a leaflet produced by the British Infertility Counselling Association (BICA) on Egg Freezing. Here, the female human egg is represented by a chicken egg surrounded by hay; the word 'Hope' is written on the egg, to further symbolise the potential to develop future life from eggs that are nonetheless represented as animal.

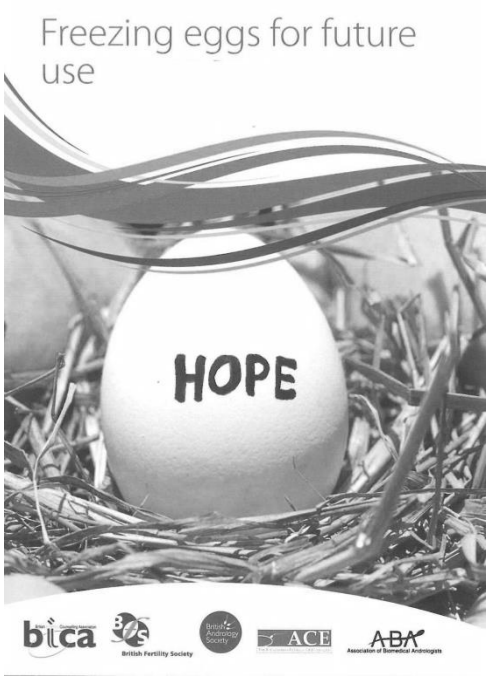


Figure 3. BICA's leaflet on egg freezing.

The animal body emerges more frequently in the active *voice*, and the *participants* in the text are more often body parts (such as embryos, sperm, and eggs). The animal body is also constructed discursively by *hiding or removing the agent* in a sentence, as exemplified in the following utterances:

> - Those [eggs] that *have been fertilised* (now called embryos) *will be grown in the laboratory incubator* for up to five days. [HFEA Booklet]
>
> - …the eggs *are cleaned* by having the surrounding cells *removed* [BICA leaflet]
>
> - …a sterile saline *is placed* into the uterine cavity through a fine catheter… the integrity of the uterine cavity *is* then *examined* by an ultrasound scan [Private clinic booklet]

Having a part of the body removed and acted upon by the clinic entails a passive treatment of the body. The above quotes show that the body is passively constructed when examined.

Further, in all sentences the actions will be carried out by healthcare professionals, most likely by the embryologists working at the clinic. By removing the agent, organisations distance a medical procedure from who is carrying it out; this in turn detaches the action from the human side of medical procedures. To put it simply, we know there is someone doing what the sentence describes, however the focus is not on who is performing the action, but rather on the action itself and on the passive subject of the action. In the first sentence, the HFEA is saying that it does not matter for the patient to know who will fertilise their eggs and grow their embryos, as long as it is done. Whereas it is implicit that the action will be performed by someone who knows how to do it, rather than focusing on the professional carrying out the task the focus is kept on the medical procedure and gaze maintained on the body part which is acted upon by an expert. The focus is kept on eggs and embryos, and that contributes to maintaining an understanding of the prospective patient that is passive and passively examined.

Examples of *nominalisations* include assisted hatching, male factor infertility, fertilisation, vitrification of gametes and embryos, insemination of eggs, assisted conception, survival of the eggs, egg collection, egg freezing, semen assessment, embryo transfer. All these nominalisations reduce processes entailing different stages of intervention on the body or parts of the body to a single term, thereby reducing the multiple steps and procedures the experts (in this case the embryologists) take in order to carry out parts of the treatment. This contributes to the construction of the animal body in two ways: 1) all the nominalisations are also true for other mammals' fertilisation; and 2) by reducing the single steps within each

procedure, the animal feature becomes invisible, but not thereby absent.

The animal body further emerges in relation to specific key words, which are highlighted in italics in the below examples.

- Before *an embryo* can attach to the wall of *the womb*, it has to break out or *'hatch'* from its outer layer, the *zona pellucida*. [HFEA booklet]
- It has been suggested that making a hole in or thinning *this outer layer* may help *embryos* to *hatch*, which may increase the chances of pregnancy. [private clinic booklet]
- A needle will be inserted into the scanning probe and into *each ovary* / and *the eggs* are collected through the needle. [BICA leaflet]
- Those that *have been fertilised* (now called embryos) *will be grown in the laboratory incubator* for up to five days. [HFEA booklet]
- An ectopic pregnancy is when *an embryo* implants outside *the womb* / It most commonly occurs in *the fallopian tube*, though occasionally an ectopic pregnancy can develop *in the ovary*. [private clinic booklet]

The above key words are all terms that are also used in animal studies in relation to animal physiology and reproduction. Any of these sentences could be applied for most mammals (see Gordon, 1996; but also Bearden et al., 2004), but the context and reasons for constructing the human body as animal differ from the ones employed in the case of the fertilisation of animals, most notably cattle.

The use of specific scientific terms deriving from biology and animal reproduction can further be interpreted as a way not

to patronise the prospective patient: simplifying the terms would imply an understanding of the prospective patient as incapable of discussing her reproduction in technical terms. Thus the construction of the animal body can be seen as necessary for an organisation-prospective patient interaction grounded on a strictly scientific approach to infertility.

Below are examples of pictures used in the analysed organisational texts where the animal body emerges.

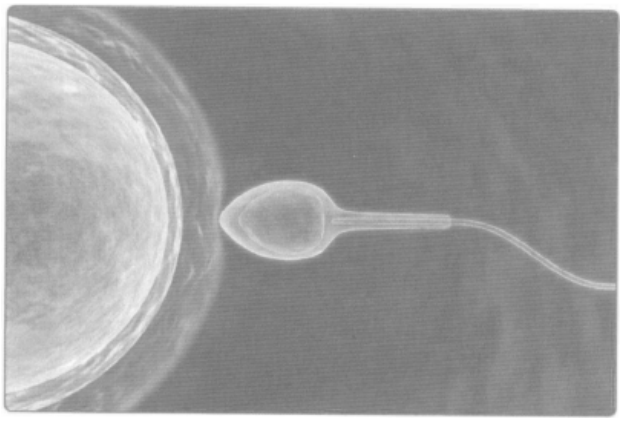


Figure 4. Egg and Sperm, HFEA booklet

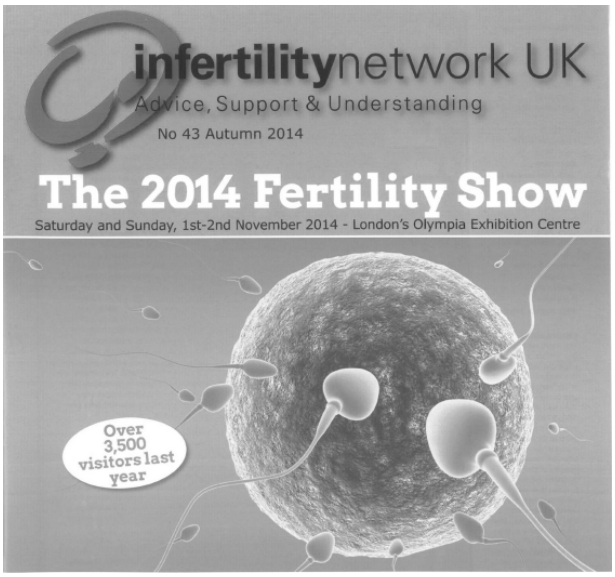


Figure 5. Egg and Sperm, IN UK issue front page

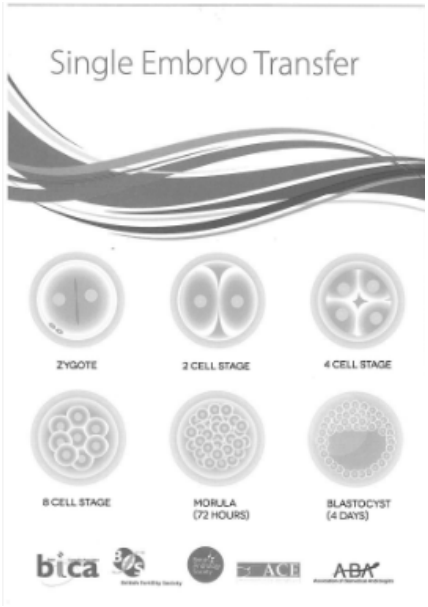
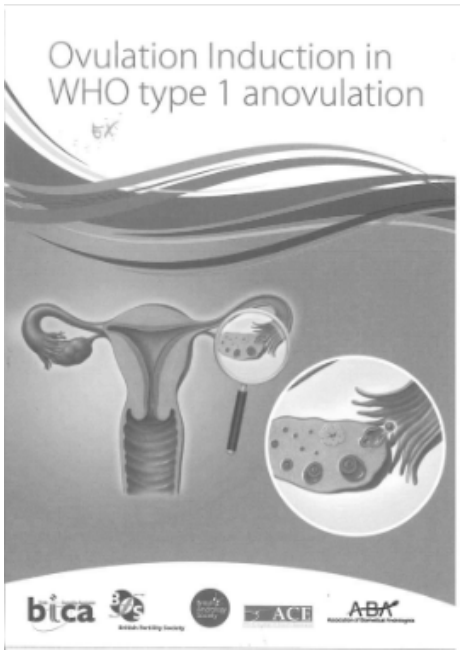
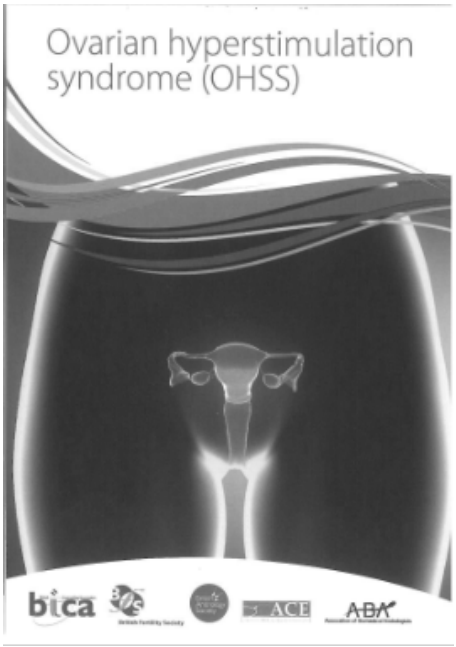


Figure 6. BICA leaflet on Single Embryo Transfer

These pictures could all be representing any mammal's egg being fertilised. The way the prospective patient is being constructed as they see the picture is animal: it is implicit that that is going to be the prospective patient's egg, but at the same time there is no caption specifying that *that* is a human egg.

Other examples can be seen in these BICA leaflets (figures 7 and 8 respectively):





Figures 7 and 8. Ovulation Induction in WHO type 1 anovulation, BICA leaflet (figure 7), and Ovarian hyperstimulation syndrome (OHSS), BICA leaflet (figure 8)

Pictures representing the animal body stress that the focus of the overall discourse on human reproduction, at least when it comes to the medical side of it, rather than being on the body as a whole, is only on parts of it: this locates any fertility issue inside of the patient, but it is observed from a detached position. If anything is not working correctly, it is not you: it is a *part* of you, and this part can be corrected, removed, enhanced, or examined.

5.4.2. The Examined Body

The examined body is the body that exists under the medical gaze. It is a body that needs testing, examining, to be closely looked at. This category 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:

1. 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)

2. 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)

There are 482 references to the examined body in the organisational texts. This discursive construction is more frequent within discourses produced by professional associations (97), the government (183), and private clinics (135). Examples of words used to construct the examined body are: to test, to undergo, assessment, to examine, to diagnose, and to check. The form is mostly active, and the agents are doctors, patients, and body parts to be examined. The examined body tends to emerge in the passive voice. In the analysed texts, the *participants* are the patients and body parts, but within this discursive construction, the agent is most often absent.

Because of the close link of this discursive construction with the presence of a medical gaze, a number of *nominalisations* are present. Examples are: fertilisation, embryo transfer, In Vitro Maturation, and blastocyst transfer, intrauterine insemination, Uterine Cavity Assessment. It is perhaps not surprising to see nominalisations more often in this discursive construction than in others, as nominalisations collapse a process into a singular moment: the many steps

involved in the processes of, say, fertilisation or embryo transfer are concentrated into one process. This use of nominalisation hides a broader construction of the examined body: within the process of fertilisation, the body is examined multiple times through the various steps that the process entails. Using the nominalisation of 'fertilisation', for instance, concentrates the construction of the body as examined into one, singular case. In a way, the use of nominalisation hides the fact that the body is constructed as examined more often than we might at first read in the text. As Fairclough notes, nominalisations allow for the "systematic mystification of agency" which in turn "allow[s] the agent of a clause to be deleted" (Fairclough, 1992: 27).

Common *key words* related to the examined body are: investigation, treatment, to establish, test, monitor, scan, collect, and select. They more often appear as verbs without an agent: the actions are performed on the body in order to examine it, but the stress is on the performed action, not the agent. This has already been noted in section 5.4.1 with regards to the construction of the animal body.

Examples are as follows:

- The scan involves *assessment of the uterus, ovaries and fallopian tubes*
- *The optimal starting dose* of stimulation drugs *is carefully evaluated* based on patient hormone profiles
- …your ovaries will be *regularly scanned during treatment*
- In a quarter of cases, despite *investigations*, a clear *cause* of infertility is never *established*. This is often called unexplained infertility.

- Our … *close monitoring* of the patients.

Another feature of the examined body that emerges from these examples is the *regularity and consistency* with which the body is being examined: it is rarely an examination happening *una tantum*. Instead, the body needs to be monitored throughout the drug treatment, or regularly scanned. The examined body often emerges in pictures representing fragments of the body that are kept under close examination and monitoring.

Examples are provided below:

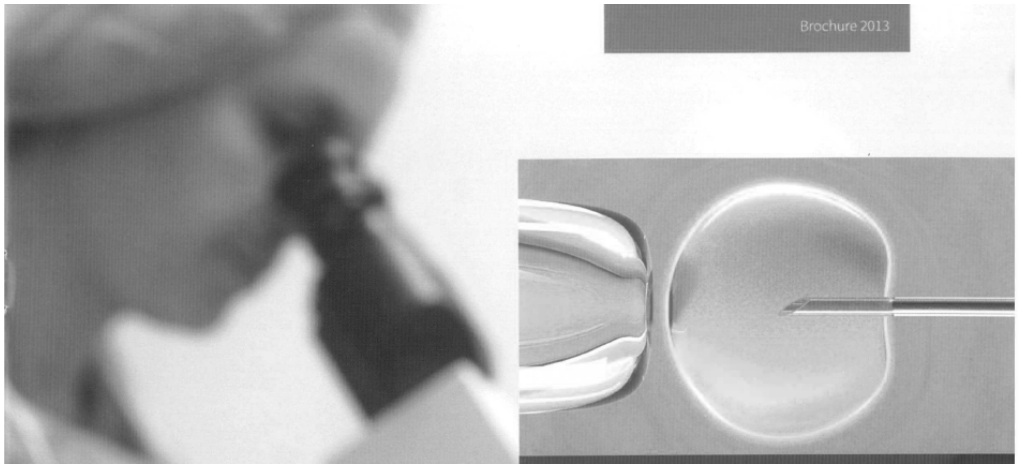


Figure 9. Examined body, private clinic booklet #1

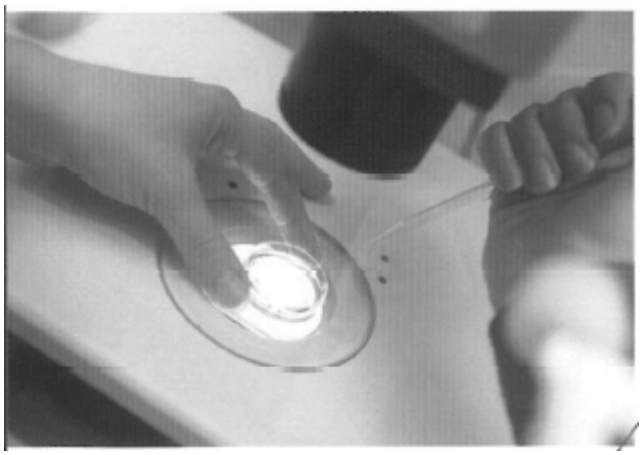
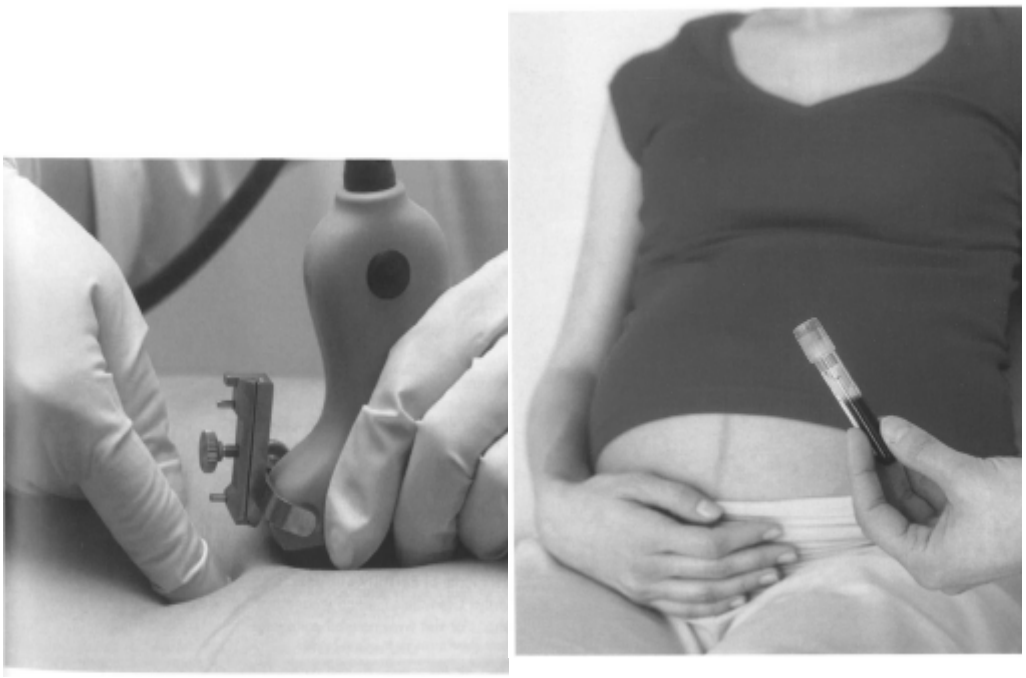


Figure 10. Examined body, private clinic booklet #2



Figures 11 and 12. Examined body, Fertility Road magazine issue

The next section provides some overall reflections on the discourse of the medical body.

5.4.3. The Medical Body: A Positivist Discourse of a Flawed Body

The constructions of the body as animal and examined create a positivist understanding of the same body, grounded in scientific language and discourse, and removing any context to infertility. Indeed, the inability to reproduce is here exclusively constructed as a medical issue.

Further, the medical body is a body that is understood as essentially flawed. As shown in the examples provided, words used to construct the medical body presume that anyone approaching the organisations, or attending the Fertility Show, is experiencing fertility issues. While this can be the case for a number of people attending the Show or contacting the

organisations, the landscape of fertility treatment is more complex. An increasing number of same-sex couples and single women are using fertility treatment (HFEA, 2014), and more generally fertile people too can be involved in fertility treatment – either by being single women searching for a sperm donor, donors themselves, or same-sex couples. These *fertile* bodies are not represented by the medical body: by being at the Fertility Show, it is assumed that there is something wrong with the prospective patient, who is understood as in need to be treated.

5.5. Discourse of the Distressed Body

The discourse of the distressed body includes the discursive constructions of the distressed body and of the successful body. Discourses constructing the body as emotionally distressed point toward an understanding of infertility as an experience defined by grief and wrongness, or as a problem to be solved at all costs. Such an approach opens possibilities for the justification of tests, analyses, and counselling. However, the same discursive construction also implies the need to *fix* the dysfunctions of the body through any non-medical approach available, such as for instance astrology, vitamin supplements, nutritional advice, and so on. These approaches were represented by numerous small businesses exhibiting at the Show and attracting large numbers of visitors, despite being at the periphery of the organisation field. Importantly, the discourse of the distressed body places infertility beyond the medical level, as if the prospective patient was in distress just by *being* there. The distressed body, then, is a discourse that emerges in opposition to that of the medical body, where the focus is maintained on parts of the body that are not 'working' and need to be fixed through a scientific and

medical approach. The distressed body positions the distress (or the dysfunction, that which does not work) on a higher and broader order, beyond medical tests and scientific approaches and within the prospective patients' personal and emotional experience.

The distressed body is thus a body that only exists in relation to fertility when in a state of emotional distress. The message sent to the female non-reproductive body is clear: you cannot be childless *and* happy. By being childless, the body is socially dysfunctional and hence unhappy. The state of emotional distress, however, can only terminate once a live birth has been achieved: the prospective patient will likely suffer pre-, during, and post-treatment (if failed). Their emotional suffering is assumed by all organisations.

This notion of the distressed body is further highlighted by its opposite, the discursive construction of the successful body. Here, success is centred on either reaching pregnancy or a live birth. The notion of success and the one of happiness are closely linked, and connect to the construction of emotional distress. This construction suggests that success (hence happiness) is only possible if one has a family - that is, through successful treatment and outcome (having a child). Any other outcome would instead lead to the continuation of a state of emotional distress. We can thus notice an underpinning binary within the discourse of the distressed body: an infertile body is conceived as distressed, whereas a fertile body is understood as successful.

5.5.1. The Distressed Body

The discourse constructed around emotions and infertility suggests that being childless and seeking fertility treatment to

relieve the status of childlessness causes strong emotional distress. The prospective patient's emotional suffering is assumed and discursively constructed by all the analysed organisations attending the Fertility Show.

Examples include:

1. 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)
2. No-one should face the *heartache of struggling* to conceive *alone* and we are with you every step of the way (NGO newsletter)

There are 557 references to the category of distress in the organisational texts. This discursive construction is more frequent within discourses produced by NGOs (255) and other businesses (228), whilst it is emerging the least in discourses produced by private clinics (74). Examples of words used to construct the category of distress are: support, help, difficult, feel, stressful, overwhelmed, to cope, challenges, to deal with, rollercoaster. The form is active and the prospective patient is often the agent. The body constructed in a state of emotional distress is always present in the active *voice*, with the patient being the main *participant*, followed by some type of treatment. Unlike most of the other discursive constructions, the agent of the actions through which the emotionally distressed body is constructed is most often explicit.

Nominalisations are absent, in virtue of the fact that the cause of distress is not placed directly in relation to a series of procedures that can be nominalised into one single step (as in

the examined body, for example, where nominalisations such as 'single embryo transfer' are found), but rather it is placed in a state and a social condition - that of being childless. Key words related to this discursive construction are: stressful, anxieties, emotions, rollercoaster, frustrated, confusing and intimidating, feelings, help, support, to feel, emotionally draining, to fail. Adjectives and nouns tend to be used more often within this discourse than within the discourse of the medical body. The use of these words constructs a body that is in a negative emotional condition before, during, and sometimes after treatment (particularly if unsuccessful). For example, the HFEA provides information on counselling and on the risks and/or negative outcomes that could follow IVF: the use of such words is a way of acknowledging that the process of fertility treatment is not a simple one, and that it will have an impact on the prospective patient's emotional state. Nevertheless, by doing this, the HFEA is also conveying an understanding of the patient who is always in a state of suffering. This might not always be the case.

Examples in the analysed texts are:

- It is important that *you feel* you are making a choice to stop treatment / and that it is not a sign that *you have failed*, or *not done enough*
- If you're *having trouble* becoming pregnant, *you're not alone*.
- It is important to make sure that you share *your thoughts and anxieties* with the doctors and nurses treating you.
- The science and medicine involved can be *confusing and intimidating* (HFEA booklet)

- …she took steps to *deal with her emotions* by adopting a *coping strategy* in certain situations (Other business, Fertility Road magazine)

The words constructing the distressed body have to do with more or less strong negative feelings or consequences, such as fear and failure. It is important to stress that in the text the prospective patient will seldom 'think' that they have not done enough, or 'think' that fertility treatment will be a rollercoaster. Instead, the patient *feels*, but this feeling is rarely positive. Further, the discourse of the distressed body directly addresses the prospective patient through the use of the pronoun 'you': this brings the person and their experience into the discourse, in stark contrast to the medical body where context and personal pronouns are absent. The distressed body is a discourse that includes the person and their experience of infertility: in contrast to the medical body's detachment from the individual, the distressed body entails a component of attachment to the prospective patient's situation. Here, treatment is viewed as a way to relieve the patient from her state of grief. This differs from the medical body, where detachment from treatment is needed because it is *a part of the patient's body*, and not their individual experience of infertility, that is not working as it should.

The distressed body appears in pictures related to failed IVF treatment, or to negative emotions that are due to childlessness. The person portrayed in distress is mostly female.

Figure 13. Distressed body, private clinic booklet

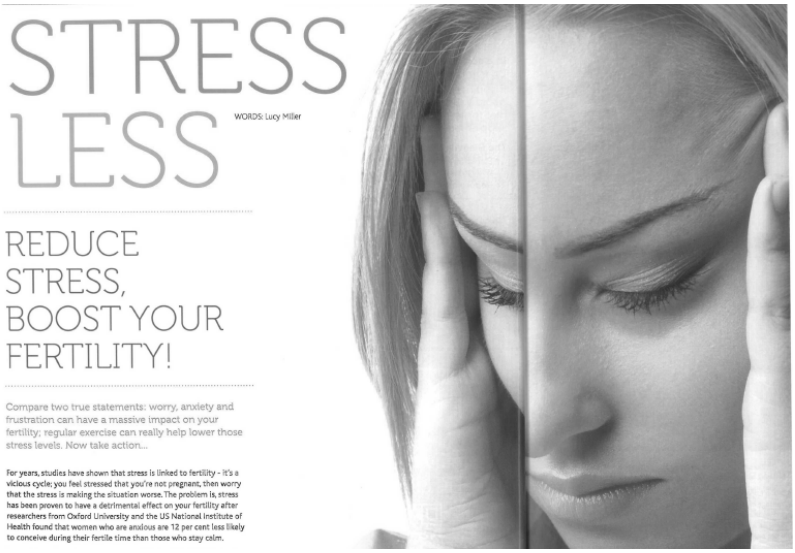


Figure 14. Distressed body, Fertility Road magazine issue

5.5.2. The Successful Body

Discursive constructions of success are centred on either reaching pregnancy or a live birth. They are closely linked, and connect to the construction of distress. The construction of the successful body, however, seems to suggest that success (hence happiness) is only possible if one has a family - that is, through successful treatment and outcome (having a child).

Any other outcome would instead lead to the continuation of a state of distress.

Examples are as below:

1. *Dreams can come true* (other business, Fertility Road magazine)
2. Many couples are *extremely grateful* to her (other business, leaflet, astrology-related services, customer's testimonial on the business owner's success)
3. …patients in the UK who require IVF in order to *complete their families* (IN UK)

There are 324 references to success in the organisational texts. This discursive construction is more frequent within discourses produced by private clinics (107) and other fertility-related businesses (95). It is least emerging in governmental discursive constructions (34). Examples of words used to construct success and happiness are: dreams, pregnant, to become, to come true. The form is active, and the agent is the patient striving to achieve their goal of having a baby. A successful body is constructed in the active *voice*, and the *participants* are either the prospective, current, or past patient. There are no hidden agents, and no nominalisations. Significantly, a body that is discursively constructed as successful only when able to give birth to biological offspring is a body that will not be as successful if it becomes pregnant thanks to adoption or fostering. Key words associated with the successful and happy body are: to fail, outcome, chance, and success.

Examples are:

- Michelle and David had various fertility treatments and sadly still do not have *a positive outcome* (HFEA booklet)
- It's only natural for you to want to know your *chances of success* (HFEA booklet)
- Everywhere I turn there are *pregnant ladies* or *proud dads* pushing a pushchair or *little ones* shouting for *mummy and daddy* (IN UK article written by IVF patient)
- [the clinic] can give you the extra help you need to safely navigate the obstacles *keeping you from your dream of having a baby* (Private clinic booklet)

Similar to the distressed body, the use of nouns and pronouns personalises the successful body and brings attention to the context where infertility happens. The successful body is constructed as such in relation to its potential: it is not successful *yet*, but it will be once treatment leads to a live birth. The words '*your chances of success'* appear often in the analysed texts, suggesting that this success is related to 'chances' that ultimately are dependent upon the individuals approaching the organisation. If you are not being successful, it is because you are not approaching the right organisations, having the 'right' lifestyle, or being proactive enough. The potential for success is not there yet, and the chances of it being there in the future are low. Yet the discursive construction of the successful body can send a strong message to the prospective patient: you are not being successful now, but you might have a chance to be in the future, thanks to us. Nevertheless, however low the chances may be (only 26.5% of IVF treatment will lead to a live birth) (HFEA, 2016g), they do

not depend on the organisations exclusively, but on other factors that emerge as the following discursive constructions: a body that needs to be taken care of by organisations (the cared for body), the body that takes care of itself through, for instance, a healthy lifestyle (self-caring body), and the body that is in control of their chances of success (in-control body). These will be discussed in section 5.5.

The successful body is mostly constructed through pictures found in private clinics' booklets and the magazine Fertility Road. This might relate to the nature of these organisations: whereas private clinics will advertise themselves as successful by showing previous patients' successes, Fertility Road provides the reader with articles about all the stages of fertility treatment – from the ones of grief and anxiety to the ones of success.

Figure 15. Successful body, private clinic booklet #1

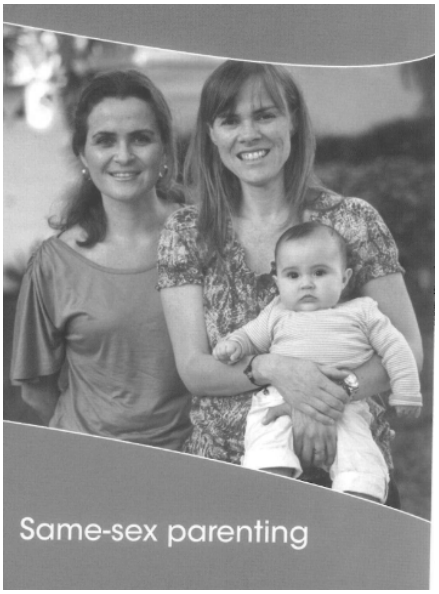


Figure 16. Successful body, private clinic booklet #2

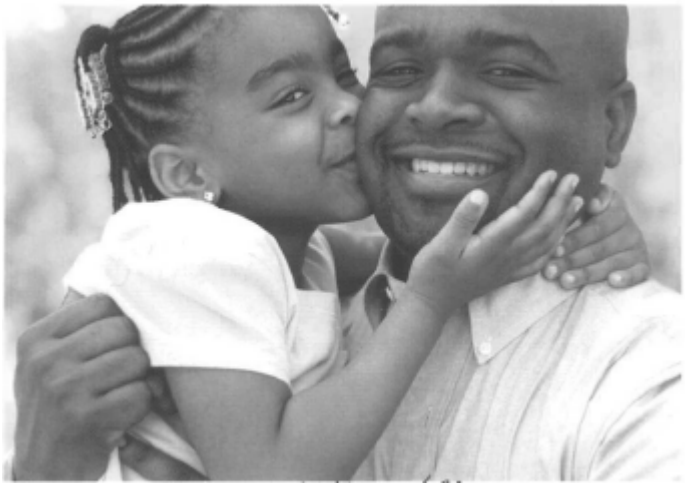


Figure 17. Successful body, private clinic booklet #3

Figure 18. Successful body, Fertility Road magazine issue

5.5.3. Relationality of Discourses: Emotional Rollercoasters and the Personification of Potential Life

Having presented the two constructions informing the discourse of the distressed body, this section discusses the relation of the distressed body and the successful body in the texts, as well as two significant themes which emerged in the analysis: fertility treatment as a journey and emotional rollercoaster, and the personification of the potential future life.

The constructions of the distressed body and the successful body, despite being in a dichotomous relation, are often constructed tightly together in the texts. The booklets of two private clinics exhibiting at the 2013 Fertility Show read:

> "The Joy of Life.
>
> *Becoming a parent is one of the most joyful and satisfying experience possible*. At Fertility Plus we wish to *make your journey fulfilling* by offering you ethical personalised care, giving you the *best possible chance to become pregnant*."

"…we have years of experience in *helping couples* to create the family *they've always dreamed of*."

Here we can see how the construction of success ('becoming a parent', 'become pregnant') is closely related to feelings of emotional satisfaction ('the joy of life', 'is one of the most joyful and satisfying experiences possible', 'fulfilling'), thereby implying that the opposite state – the absence of parenthood, hence the absence of 'life' – will not provide the prospective patient with a fulfilling life, joy, or satisfaction.

Similarly, the 'joy of motherhood' is a very painful absence that constructs a distressed body while simultaneously fuelling conceptions of what a successful body should feel and look like:

"…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*" (excerpt from Fertility Road 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 an IN UK volunteer, IN UK magazine)

Again, we can see how within the discourse of the distressed body, constructions of the distressed and successful body coexist and 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). In the second excerpt, the 'feeling of failure' (distressed body) experienced by the IN UK volunteer arises whenever she sees 'a happy family' (successful body); the body is so distressed that even when attempts are made to remove the distress (in the example provided, through anti-depressants), success is not achieved because the woman is not going to become a mother.

The discourse of the distressed body is present within the field also through the metaphor of fertility treatment as an 'emotional rollercoaster' or a 'journey' where the emotional lows are deemed worthwhile in light of the potential future life that will complete the family and relieve the distressed body from its emotional suffering:

> "The staff…gave me all the time and individual care I needed during *my roller coaster journey to parenthood*" (private clinic booklet, former patient)

> "*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*." (Description of a seminar, Fertility Show guidebook, 2013)

The 'bumpy time' due to the 'fertility rollercoaster' is something the prospective patient is constantly being warned about, but it is also the only journey able to relieve the distressed body from its inherent suffering. What makes it worthwhile is the potential future life: in order to make the bumpy journey worthwhile, organisations will attribute human qualities to the embryo and/or the egg, as shown in the following excerpt from my 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"* (Fertility Show field notes, 2014)

In a field environment that beautifies and exalts the embryo, women who are unlikely to reach 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, field notes 2/11/2014)

This however is not explicitly used to construct the woman as a distressed body. Instead,

> *"Women **are special** and are born with a certain number of eggs", while men produce sperm every 30min or so"* (Medical director of fertility clinic 2, field notes 3/11/2013)

What makes women special is what also removes agency and experience from them: the diminishing number of eggs with age makes the event of a fertilised embryo something to be cherished because of its ability to generate a future life. The future life is thus personified at an incredibly early stage, as shown in the below picture taken from a private clinic booklet:

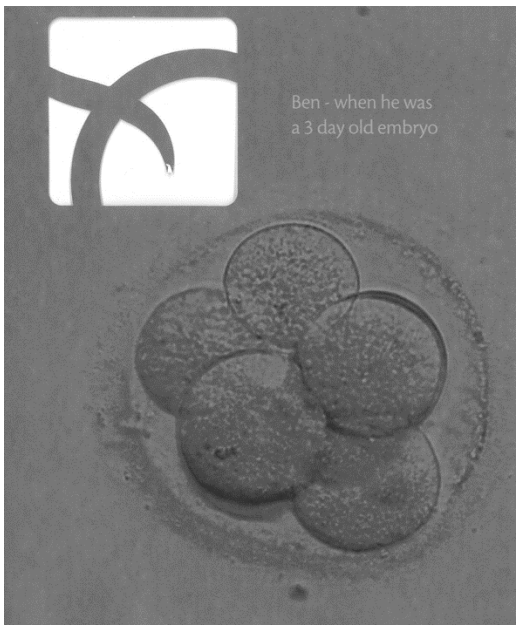


Figure 19. Personification of potential life. Private clinic booklet first page. The caption reads: "Ben – when he was a 3-day old embryo".

The personification of future life thus adds a further component of distress to the distressed body, so that the prospective patient will be assumed to be in distress if the potential future person (the embryo) does not become a live baby – thereby making the bumpy rollercoaster journey of fertility treatment useless and unfruitful.

5.6. Discourse of the Cared for Body

The cared for body is a discourse entailing the discursive constructions of the cared for body, the self-caring body, and the in-control body. The concept of care refers to organisations taking care of the prospective patient, hence positioning

themselves as active (see excerpts like 'let us take you there, we know the way' or 'our fertility counsellors are here to provide additional support at all times') and the patient as passive, in needing to be taken care of. Care is something the prospective patient *will be provided with* by the organisation. This can take five different forms: empathising, patronising, supporting, teaching, and treating.

The discursive construction of the self-caring body suggests that the female non-reproductive body will need to be proactive with regards to certain procedures before, during, or after treatment if a successful outcome is to be reached. The body is required to take steps for their own benefit, and these steps cannot be taken by anyone else but the patients themselves. Self-care is *expected from* the female non-reproductive body.

A body that is in control refers to the idea that the body has control over some of the process of fertility treatment. Private clinics state that they 'will do whatever it takes to live up to your expectations', or make sure that patients know that they can always change their minds about, for instance, what to do with their frozen eggs or sperm. 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 one's reproductive future, however medically uncertain it may be. Being in control is here understood as a form of care because it is constructed as something that will help toward successful treatment: powerlessness is a feeling that only maintains the body in a distressed state associated with childlessness.

Overall, the discourse of the cared for 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 a lot of responsibility and gives a sense of accountability for failure (if you didn't get pregnant then you didn't try hard enough/your lifestyle is not healthy enough, etc.); whereas the in-control body is given, by the organisations constructing it, a sense of control not just over the process of treatment, but over the outcome as well, thus reducing the feelings of passivity and powerlessness throughout treatment. In the case of private clinics, this might be used to maintain the prospective patient in a state of returning customer: if the treatment did not work the first two times, it was because you were not taking the lead over the process enough.

5.6.1. The Cared for Body

The concept of care refers to actors taking care of the female body, hence positioning themselves as active and the body as passive and in need to be taken care of. Care is something the prospective patient will be provided with by the organisation.

There are 350 references to the category of care in the organisational texts. This discursive construction is more frequent within discourses produced by private clinics (77) the government (68), businesses (49) and NGOs (49). It is well spread between organisations.

Care, however, can take five different forms: empathising, patronising, supporting, teaching, and treating.

*Empathising***.** The organisation 'understands' the difficulties the female body faces when opting for fertility treatment; taking care of them means having the empathy to provide everything the body may need because 'we know what it feels like'.

Examples:

1. It is helpful to speak to someone independent *who will neither judge you* nor give you advice (Professional association leaflet)
2. *You are not alone* (NGO newsletter)

Patronising. Taking care of the body can also emerge as a patronising act. Excerpts like 'Walking. It's free – and good for you!' is not only recommending an activity that might improve one's fertility, but is also implying that the body is unable to fully take care of itself, or know what will benefit them. Organisations will patronise prospective patients by suggesting, clarifying or stressing information, activities and actions that the prospective patients, and indeed most people, would understand without the need for any further explanation.

Examples:

1. *Don't panic*! (Professional association leaflet)
2. Need some help *getting to your optimum weight* to conceive *without getting hungry*? Then *snack on almonds* (other business, fertility magazine)

Supporting. The organisation provides help to the body in a variety of ways such as counselling or a listening ear. This emerges often with regards to counselling, which clinics are required to provide by governmental guidelines.

Examples:

1. So that you can explore different ways of coping, with someone who is *trained to listen and support you* (Professional association leaflet)

2. Free Support line, which has been described as a lifeline by many patients who have no-one else to talk to and *don't get the support and counselling they need* (NGO newsletter)

Teaching. Taking care of the body also takes the form of teaching them about fertility, infertility, reproduction, treatment, tests, and biology. Prospective patients are constantly taught about their own bodies and what medicine (clinics) can provide them with in order to successfully deliver a healthy baby.

Examples:

1. 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)
2. *Information* regarding care and treatment options *should be provided in a form that is accessible* to people who have additional needs, such as people with physical, cognitive or sensory disabilities, and people who do not speak or read English (NICE Guidelines)

Treating. This category mainly refers to private clinics, pharmaceutical companies, and NHS foundation trusts that talk about treatment as a way of caring for the patient. Often treatment is described as helping the patient fulfil a dream.

Examples:

1. Patients should be *offered a blood test* to measure serum progesterone (NICE Guidelines)
2. We were very sure that *with our tried and tested deep*

cleanse programme we would be able to help (nutrition business advert in fertility magazine)

Examples of words used to construct the category of care, in its various forms, are: to help, to give, to inform, to support, to advise, to treat, to test, to examine. The form is mostly active and the agents are the clinic, the specialist, or the doctors. The cared for body is constructed in the active *voice*, and the *participants* are more often prospective patients, the clinic, and the government. There are only a few *nominalisations* in relation to this discursive construction, which emerge in texts produced by businesses and by private clinics. Examples of *nominalisations* are fertility tracking, fertility check, individualised care, personalised treatment.

Key words used include help, monitor, clinic, ensure, support, help, and using the form '*you may want to*' in relation to the choices the body has with regards to specific decisions. 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 a 'present' organisation throughout the female body's fertility journey can also be noted. In the selected texts, care is mostly discursively constructed as support, teaching, treating, and empathising. Patronising emerges less often, but it is nonetheless present – particularly in the magazine Fertility Road.

Examples are:

- Support groups, websites and professional counsellors *can all have a role* to play in *helping you* through the journey [teaching; support] (HFEA booklet)

- Making decisions together and understanding the reasons for your choices *will help you* get the most out of your treatment [teaching; empathising] (HFEA booklet)
- *we provide* data on success rates for every licensed clinic [teaching] (HFEA booklet)
- *you may want to consider* counselling [support; empathising] (HFEA booklet)
- *Counselling* has been a wonderful *aid* [support] (IN UK, letter from current IVF patient)
- Infertility Network have a wealth of *information and support* for people like myself [support; teaching] (IN UK, letter from previous IVF patient)
- the clinic should take *your welfare* very seriously and aim to *provide you with an excellent service* [treating; support] (BICA leaflet)
- …the ultimate rundown of 26 *things that will get you in perfect fertile shape* [patronising] (Fertility Road magazine)
- *Laughter really is the best medicine* [patronising] (Fertility Road magazine)
- Need some *help getting to your optimum weight to conceive* without getting hungry? Then snack on almonds [patronising] (Fertility Road magazine)
- *We understand* [empathising] (Private clinic booklet)

The cared for body is constructed as a passive body that requires 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, initial proactive steps will have to be taken by the female body in

order to be cared for by the organisation and hence getting closer to being successful.

The cared for body is mostly constructed in pictures found in private clinics booklets, and the type of care the body is subject to is treating. Because of this, in said pictures the body is also being constructed as examined.

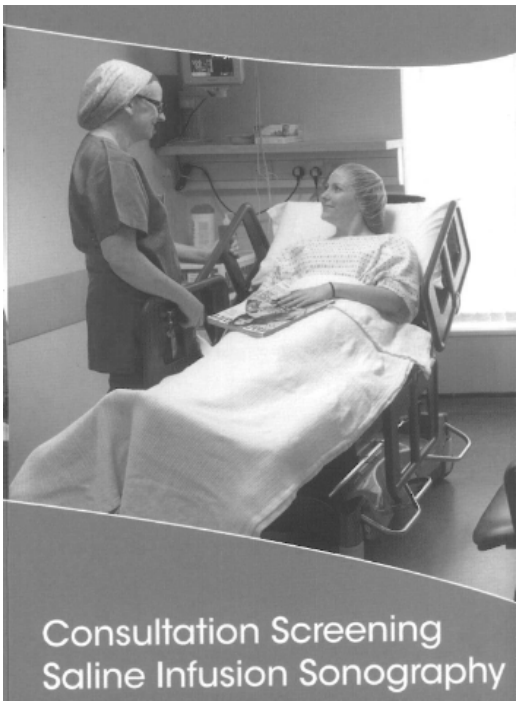


Figure 20. Cared for body, private clinic booklet

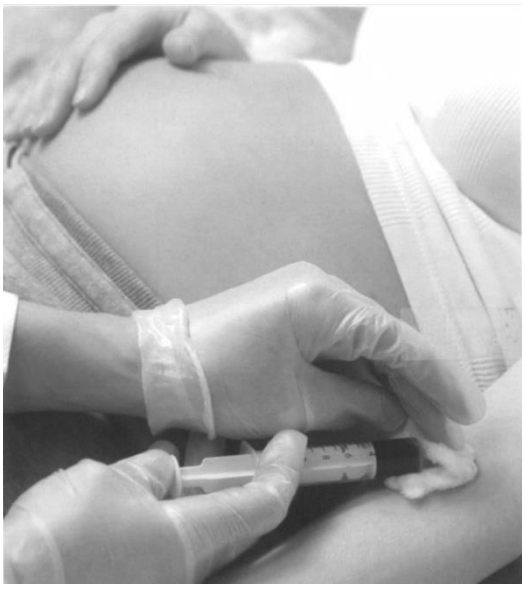


Figure 21. Cared for body, Fertility Road magazine issue

5.6.2. The Self-Caring Body

This discursive construction suggests that the female non-reproductive 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 that these steps cannot be taken by anyone else but themselves. Whereas care is offered *to* the body, self-care is expected *from* the body.

Examples:

1. 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)
2. 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 fetus. (NICE Guidelines)

Similar to the discourse of the distressed body, the self-caring body brings the prospective patient to the fore by explicitly addressing them through the use of 'you' and 'your'. There are 225 references to self-care in the organisational texts. This discursive construction is more frequent within discourses produced by businesses (97), the government (51) and NGOs (54). It is least found in discourses produced by private clinics (20). Examples of words used to construct self-care are: lifestyle, changes, should be informed, keep in check, overcoming. The form is either imperative or active, the agent is the text consumer. The body of self-care is widely present within the selected texts. It is constructed in the active *voice*, and the *participant* is in most cases the text consumer. Other participants include either the clinic or healthcare professionals, or 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 the modal verb *should*. Hence, the stress is not on a set of procedures (such as with previously noted nominalisations) but on single actions and specific practices that the text consumer should take into consideration in order to increase their chances of conception. Key words and forms associated with this body are: you may want to, to make sure, you will, you must, you should, you can, and imperative forms such as 'stop smoking', 'keep cool', 'drink sensibly', or 'think about'.

Examples are:

- It is important to *make sure that you share* your thoughts and anxieties with the doctors and nurses treating you (HFEA booklet)
- *You can* potentially *boost* your chances of conceiving by *making sure* your body is healthy enough (HFEA booklet)
- *You may want to* talk to your clinician about whether to try again (HFEA booklet)
- …*set the intention* to bring mindfulness into your day (Fertility Road article)
- The thing is, thinking is not truth, it is *just a story we tell ourselves* (Fertility Road article)
- *It is important* that *you come out of this process* not only *with a good sense of what may be causing any problems* with conception, but *what can be done about it* (Private clinic booklet)

This construction implies that the text consumer will want to take care of themselves, but also that they might not know how. 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 (care); you should talk to your clinician (self-care), but might not know which questions to ask (care). The self-caring body, although discursively constructed by all the analysed organisations, is only constructed in pictures found in the magazine Fertility Road. This discursive construction, too, appears in pictures portraying only women exercising, dieting, or taking action in order to improve their fertility.

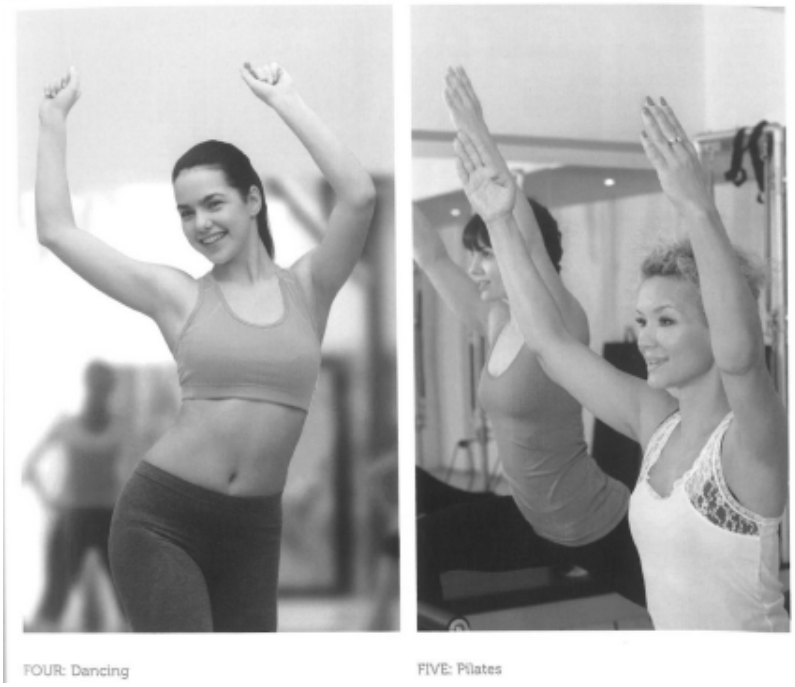


Figure 22. Self-caring body, Fertility Road magazine issue

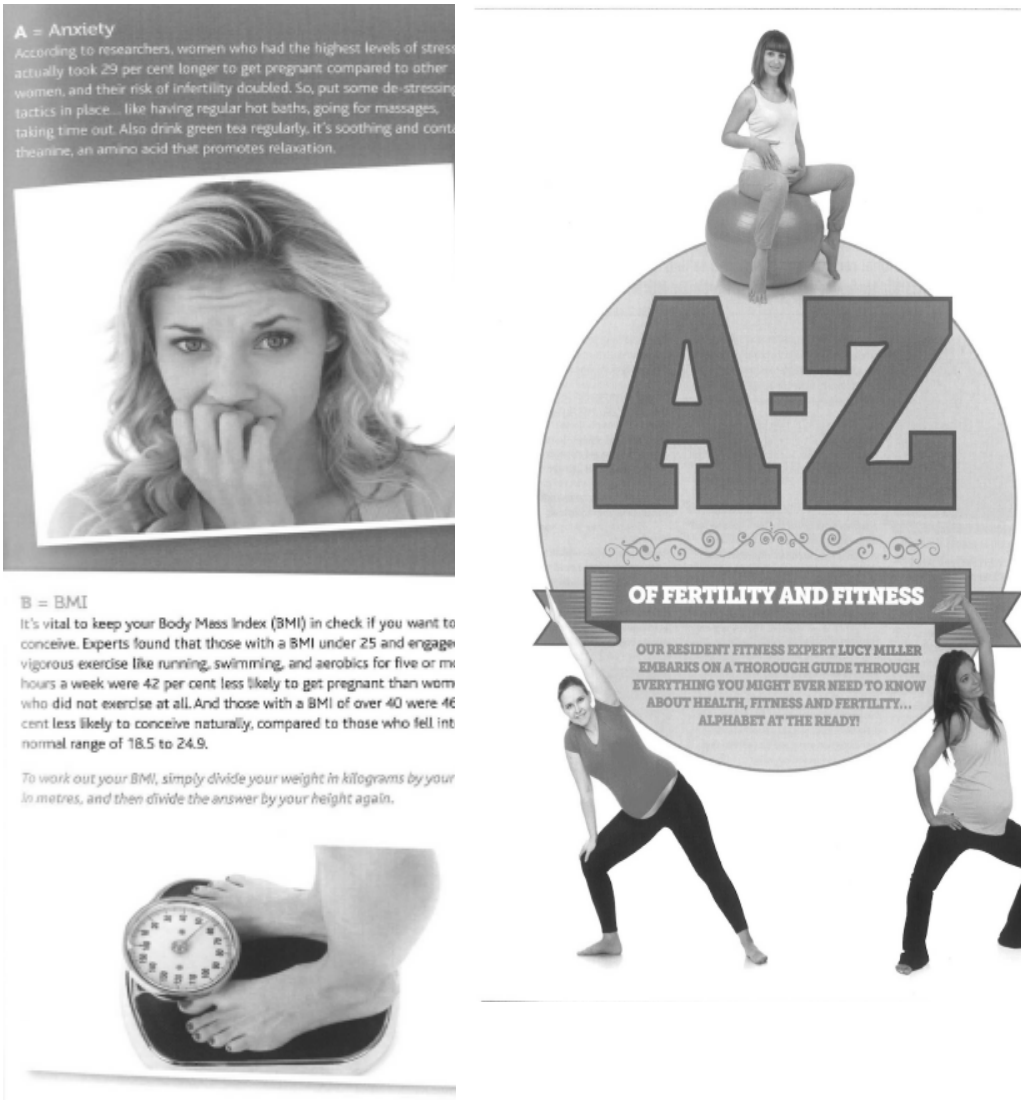


Figure 23. Self-caring body, two pages from Fertility Road magazine issue

5.6.3. The In-Control Body

This discursive construction refers to the idea that prospective patients have control over some of the process of fertility treatment. Private clinics state that they 'will do whatever it takes to live up to your expectations', or make sure that patients know that they can always change their minds about, for instance, what to do with their frozen eggs or sperm.

Examples:

1. BICA 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)

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

There are 131 references to the in-control body in the organisational texts. This discursive construction is more frequent within discourses produced by businesses (47) and NGOs (30). It is least found in discourses produced by professional associations (14). Examples of words used to construct the category of the in-control body are: to enable, to cope with, ready, consented, informed, changes. The form is active and the agent is most often the text consumer. The body that is constructed as being in control appears in the active *voice*, and the *participant* is mostly 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 is exemplified in the following excerpts:

- *Ask* lots of questions so *you feel fully informed* (HFEA booklet)
- *Exercise* regularly … *It can* also *help* reduce *your stress levels*, in what can be an emotionally draining situation (HFEA booklet)
- Both men and women *can make* lifestyle changes that may *make them more likely* to conceive (HFEA booklet)
- We can *provide you with an option* to freeze and store the good quality unused embryos, so that *you may use them* in a future cycle *without having the need to undergo egg collection* (Private clinic booklet)

- …simple changes can improve your chances of having the family you want and *put you in control* (BICA leaflet)
- Wink allows users to *take charge* of their reproductive health and their fertility goals in one seamless experience (advert in Fertility Road magazine)
- *Nothing has the power to make you feel anything*… you are living in the experience of your thinking, so you don't need to believe it (IN UK article)

The in-control body is a construction that greatly employs nouns and pronouns to directly address the prospective patient. Thus within this construction, the responsibility toward reaching 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, and that there are steps that they can take in order to make the outcome potentially positive. The in-control body differs from the self-caring body: in the case of self-care, the prospective patient is required to be proactive in relation to their chances of reaching a 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 in-control relates to a dimension of 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 it holds the female non-reproductive body responsible by providing it with a level of certainty about the possible outcome; but it also removes responsibility from the organisation, in that when the one being 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. The in-control body is rarely constructed through

pictures. This may have to do with self-care as a path to being in-control. The in-control body is a future state that is yet to come, and is the aim of any self-caring practice that might be taking place here and now.

Figure 24. In-control body, BICA leaflet

The BICA leaflet shown above suggests higher chances to conceive through change – this change involves choosing to begin some form of treatment, and will have to be initiated by the prospective patient. The patient will be in control once they decide to go for a change (which can be seen as an action of self-care): the action is more future-oriented rather than being rooted in the present.

5.6.4. Relationality of Discourses: Matters of Agency

The discourse of the cared for body entails the cared for body, the body of self-care and the in-control body. A duality emerges between the constructions identified within this discourse, and it primarily has to do with agency. The cared for

body is constructed passively and on the receiving end of the field's activities. Here, no agency is required: the prospective patient doesn't seem to have to be doing anything but being taken care of by organisations in the field. Indeed, it seems like the prospective patient *cannot* do anything but being taken care of. Self-care and in-control instead require the prospective patient to be proactive, and encourage the exercise of agency. We see the use of nouns and pronouns ('you' and 'yours' specifically), and reasons are provided as to why a certain degree of agency over the process of treatment is needed. Discourses of health, stress management, and even the management of one's romantic and sexual life are brought into focus by organisations and constructed as practices of care and self-monitoring practices that require agency.

Examples of how the cared for body and self-caring and in control bodies relate to each other in the texts are presented below:

> "Dominique… advises that women take *steps towards self-help*, as well as *seeking support from* friends and relatives, or if appropriate, *professionals*." (Fertility Road article excerpt)

Here the expert is advising women to be proactive 'towards self-help', which could entail seeking the help of a professional which will in turn take care of them. Seeking care is constructed as a form of self-care: in this example the act of self-care (seeking help) necessarily takes place before the act of being taken care of by a professional.

> "…patients *should expect the same clinical treatment* whether they are NHS or privately funded" (Professional association leaflet)

This excerpt represents another nuance of the binary care/self-care: throughout the process of treatment (while the body is being taken care of) the prospective patient ought to 'expect the same clinical treatment' from all clinics. Expecting a certain quality or level of care is thus a form of self-care that might lead to a sense of being in control of part of the treatment process.

5.7. Conclusion

In this chapter I presented the discourses of the body organisations construct at the Fertility Show. I showed the orders of coding I employed during analysis, and how they lead to the three discourses on the body I presented in this chapter (5.2 and 5.3). These are discourses of the medical body (5.4), of the distressed body (5.5) and of the cared for body (5.6). The medical body is comprised of the discourses of the animal body (5.4.1) and of the examined body (5.4.2); both advance an understanding of the body that is positivist and that removes context around fertility treatment as well as agency from the prospective patient (5.4.3). The distressed body entails the discourses of the distressed body (5.5.1) and of the successful body (5.5.2). I showed how these two discourses exist in a dichotomous relation whereby the distressed body is associated with infertility and the successful body with fertility. The two discourses further relate to a construction of fertility treatment as an emotional rollercoaster and a journey that lead to the personification of the future life. Constructing the embryo as a person, in turn, fuels conceptions of the distressed body entailing the opposition of success-fertility and distress-infertility (5.6.5). The third discourse is that of the cared for body, which entails discourses of the cared for body (5.6.1), of the self-caring body (5.6.2) and of the in-control body (5.6.3).

I discussed how the cared for body, similarly to the animal and examined bodies, is passively constructed and further removes agency from the prospective patient. On the other hand, the self-caring body and the in-control body entail a level of agency and context around infertility: here, the prospective patient is directly addressed and is expected to be proactive throughout treatment. I showed how care and self-care, despite being binary constructions, often coexist within the analysed texts (5.6.4).

The next chapter presents how organisations at the Fertility Show utilise the above introduced discourses to construct relations between themselves and the female-non reproductive body. This is done to highlight the relations at play at the FCE in order to maintain field legitimacy.

CHAPTER 6. DISCOURSE PRACTICE: CONSTRUCTING RELATIONS BETWEEN ORGANISATIONS AND BODIES

6.1. Introduction

The previous chapter showed how organisations at the Fertility Show employ the discourses of the medical body, of the distressed body and of the cared for body to configure the field. In section 2.5, I discussed how it is important for organisations to obtain and maintain legitimacy. Chapter 3 discussed how within the field of fertility treatment, legitimacy emerged around the status of the embryo, and became widely acknowledged through the creation of the Fertility Show in 2009. This chapter shows how organisations employ the discourses emerged in chapter 5 to construct relations with the female non-reproductive body - a process that in turn allows them to maintain field legitimacy at the FCE.

Specifically, the analysis shows how for each discourse constructed at the FCE, a relation is put in place by organisations between themselves and the prospective patient. Organisations thus construct the female non-reproductive body through the discourses of the medical body, the distressed body, and the cared for body; and through these discourses, they will create specific relations between themselves and the prospective patient.

With regards to the CDA approach adopted in the thesis, the chapter presents the analysis of discourse practice and focuses on subject positions. In order to do so, the attention will be directed toward two elements drawn from Fairclough's CDA: building relations through synthetic personalization and subject positioning. Together, these analytical features allow for

a number of insights to emerge regarding: 1) what relations are put in place by organisations; and 2) how organisations use the discourses on the female body emerged in chapter 5 to position themselves in relation to it.

The chapter presents how relations are built through what Fairclough calls 'synthetic personalization' (1989/2001) (6.2) and presents how each discourse emerged in text analysis engenders a specific relation between the organisation and the prospective patient (6.3). Within the discourse of the medical body, the relation in place is one that sees the organisation as a detached authority and the prospective patient as an object of the medical gaze (6.3.1); within the discourse of the distressed body, the relation is of the 'equal' empathiser and suffering 'peer' (6.3.2); and within the discourse of the cared for body, a relation that sees the organisation as a parent and the prospective patient as a child is in place (6.3.3). For each relation, modality and presuppositions are discussed. Finally, I argue that the three position construct a need for the organisational intervention into the female non-reproductive body (6.4) before concluding the chapter (6.5).

6.2. Building Relations Between Organisations and the People Attending the Fertility Show

As an organisation positions itself, it will also simultaneously relate to the subjects it is positioning. This is done through synthetic personalization, which is "the simulation of a private, face-to-face, discourse in mass audience discourse" (Fairclough, 1992: 98). It can also be understood as the "tendency to give the impression of treating each of the people 'handled' *en masse* as an individual" (Fairclough, 1989/2001: 52).

Synthetic personalization thus *builds relations* (Fairclough, 1989/2001) and creates a personalised relationship between the text producer and the text consumer. This is usually done by addressing the audience members directly by the use of imperative sentences, but also pronouns (such as *you*) and presuppositions. Building relations has an ideological component because it glues together relationships, settings, values and activities between social subjects in a way that powerfully prescribes how we should live, or how we think we should live (Fairclough, 1989/2001: 170).

Within the field of fertility treatment, the three discourses of the body are used to prescribe both the prospective patients' behaviour and the organisations'. At the Fertility Show, this is done by addressing all attendees as an individual defined by certain needs (a child or organisational care within fertility treatment) and feelings (emotional suffering) rather than a mass audience. The use of synthetic personalization can be noted in the following excerpts from data:

> "***We asked you to get behind our first ever National Awareness Week - and you did! Now we are working*** *on this year's event, so* ***make sure you save the date****: 27 OCTOBER - 2 NOVEMBER 2014. We have changed the name to National Fertility Awareness Week* ***in response to your feedback*** *to approach the fertility issues so many people face in a more positive way. The new hashtag will be #nfawuk so please* ***remember to use it*** *whenever you mention the awareness week****. It really is your week so make sure you save the dates now and start thinking about how you can get involved this year. Because we can't do it without your support!****"* (IN UK article)

> "***No matter what your situation is or who you are*** *– a single woman, single man, heterosexual couple*

with fertility problems, ***whether you're gay or lesbian*** *– at inviTRA 2014* ***we invite you to talk*** *to expert professionals, each skilled and compassionate in* ***guiding you along the road that leads to starting or extending your family.****"* (Fertility fair advert published in Fertility Road magazine)

*"****Trying to conceive?*** *The Fertility Support Programme formulated in association with Dr. Marilyn Glenville PhD, contains all the key vitamins and minerals* ***which may help increase your chances of conception. Order your first month of Fertility Support Programme and receive your FREE copy*** *of Dr. Marilyn Glenville's Getting Pregnant Faster,* ***simply quote FR0714 when ordering by phone.****"* (business advert published in Fertility Road magazine)

"Unexplained Infertility. What role does stress play? ***You could have chronic stress and not know it*** *and stress is one of the important contributors to delays in getting pregnant."* (business advert published in Fertility Road magazine)

The examples show how different types of organisation at the Fertility Show employ synthetic personalisation to construct individual text consumers, and thus build a personalised relation with them as prospective patients. The text will be read by a vast number of people, addressed as individuals.

Each organisation uses the three discourses of the body to build specific relations through synthetic personalization, which allows organisations to position the subjects in relation to themselves. Organisations, then, will simultaneously position themselves in a certain way and position the prospective patient in a certain way. These will depend on the discourse of the body that is being drawn upon and is analysed by looking at modality and presuppositions. I present the identified subject positions in the following section.

6.3. Positioning Organisations and Bodies

Discourse practice analysis is carried out by focusing on *modality* and *presuppositions*. Together they form the basis of my analysis of *intertextuality* (see section 4.9.2), and allow me to examine how organisations position themselves in relation to prospective patients. As previously mentioned, this chapter presents the discourse practice in-depth analysis of 5 organisations attending the Show, one per each type of exhibiting organisations.

In sum, the analysis shows that organisations construct themselves differently in relation to the female non-reproductive body depending on the discursive construction of the body they are drawing upon: 1) they *distance and detach* themselves from the *medical body* while at the same time positioning themselves as *authority figures* in relation to the medical body; 2) they position themselves *as 'equal' empathisers* in relation to the *distressed body*; and 3) they position themselves as *parental figures* in relation to the cared for body.

Consequently, the organisations construct the female non-reproductive body differently depending on the discourse of the body they are drawing upon: the body will be an *object* when positioned in relation to the medical body; a *suffering 'peer'* when positioned in relation to the distressed body; and a *child* when positioned in relation to the cared for body. The next sections are dedicated to presenting each positioning through selected analysed data. For each positioning I provide analysis samples to illustrate the 'findings'.

Table 11. Subject Positioning.

Discourse of the Body	Positioning of the organisation (text producer)	Positioning of the female body (text consumer)
Medical body	Detached authority	Object
Distressed body	'Equal' empathiser	Suffering 'peer'
Cared for body	Parent	Child

The selection process for the presented texts are excerpts from the five organisations specified in section 4.9.2. Specifically, I selected: from governmental organisations, the HFEA's booklet "Getting started Your guide to fertility treatment"; from private clinics, The Fertility and Gynaecology Academy's 2014 booklet; from NGOs, IN UK's Autumn 2014 magazine issue n. 43; from professional associations, the UK Professional Fertility Societies' set of 18 leaflets of various fertility-related topics; and from other fertility-related businesses, Fertility Road's magazine issue 23 Nov/Dec 2014. These texts were selected because the organisations: a) were centrally involved at the 2013 and 2014 Show; b) delivered various seminars at the FCE; c) had a strong reach to the public attending the Show; and d) are particularly relevant in the field of fertility treatment. The excerpts I present come from sections in the data where discourses of the medical, distressed, and cared for body emerged.

6.3.1. The Medical Body: Organisations as Detached Authorities and Bodies as Objects

> *2/11/2014. A medical director of a fertility clinic is giving a speech on infertility. He is telling us that when women are a female foetus in the womb, they are given the amount of eggs for their lifetime, which then diminishes over time. Some women are born "with less amount of eggs than normal". He describes the tests that can be taken to know about the quantity and quality of a woman's eggs. If the FHS (Follicle-Stimulating Hormone) level is up in the tests, he warns us, then the eggs are failing. … Further tests should be carried out, and inspections of the woman's womb and reproductive system need to take place.* [Field notes, Fertility Show 2014]

This excerpt shows the construction of the medical body both through the construction of the animal body ('the eggs are failing'), and of the examined body ('tests can be taken', 'inspection of woman's womb'). The discourse of the medical body constructs a female body that needs examination and medical intervention. Through these examinations and interventions, the female body will be looked into, and parts of it will be judged, if needed, as successful or 'failing'. While constructing and normalising this body, organisations position themselves as detached authorities in relation to a body that is, first and foremost, conceived as an object. This subject positioning is presented in the following analysis samples. The numbers to the right indicate the line number I will refer to in the analysis below the excerpt.

Table 12. Discourse Practice, Medical Body, Sample 1, Excerpt A: UK Professional Fertility Societies

A. Freezing and Vitrification of Gametes and Embryos. - Eggs, sperm, ovarian tissue and embryos can be stored - Freezing increases the chances of a pregnancy from a single egg collection which reduces risk and expense - Not all patients will have embryos suitable for freezing - Cryopreservation may be included in NHS treatment but may be charged separately in private treatment - Cryopreservation is routine in fertility clinics and is believed to be safe - Legally samples can be stored up to 10 years; with a medical reason this can be extended to 55 years.”	1 5 10 15 20

The positioning of the organisation as detached authority and prospective patient as object emerges through the analysis of modality and presuppositions.

The modality present throughout these excerpts is objective. Objective modality de-personalises the context where the action takes place and separates the actors involved from the action. This can be seen in *excerpt A*, lines 3-20, where information is not only delivered in short, to-the-point bullet points, but it is also presented as a list of objective facts the organisation knows and the reader needs to know, or is expected to need to know. The objectivity of facts is delivered

through the use of *categorical modality*: we would not question, for instance, the sentence in line 18 [Legally samples can be stored up to 10 years; with a medical reason this can be extended to 55 years], which directly refers to a legal fact existing outside of this text. The organisation does not need to quote directly from the legal text in order to prove that the information is correct: its knowledge is assumed and delivered as given.

Table 13. Discourse Practice, Medical Body, Sample 1, Excerpt B: UK Professional Fertility Societies

B. Ovarian hyperstimulation syndrome (OHSS) • "Clinics should have protocols in place to manage the risk of OHSS which include a pathway to refer patients to hospital if required. • All women being given gonadotrophins should be informed of the risk of OHSS by the clinic • Written information from clinics should outline what symptoms women should look out for and should also include 24 hours contact details • Women who are admitted to hospital (for any reason) whilst taking gonadotrophins should let medical staff know they are undergoing fertility treatment • Women with mild or moderate OHSS can usually be managed as an outpatient, but in severe cases may need to go into hospital • Most women with OHSS will recover with simple pain relief and	21 25 30 35 40 45

after being given fluid to drink, but other treatments may need to be given and sometimes fluid may need to be drained from the abdomen • Women who develop OHSS and become pregnant may need to continue treatment during the first trimester"	50 54

Excerpt B. Objective modality is present, and sentences are organised and presented again as bullet points, quick to read and giving concise, objective facts about the behaviour to be expected from clinics and women exhibiting symptoms. The text is directed to female readers who, through the text, are gendered by the organisation as women, except in line 26 where the use of the gender-neutral term 'patients' is used. The organisation's use of auxiliaries is particularly helpful in identifying how the female body is positioned: through the auxiliary *should*, the organisation prescribes clinic's and medical staff's behaviour in relation to the patient [line 22]. It further constructs the female body as a passive subject and object onto which *other treatments may need to be given and sometimes fluid may need to be drained from the abdomen* [lines 47-50]. Line 51 presupposes a noteworthy understanding of the reader and positions the organisation as detached: only female bodies can develop OHSS, so we might expect the organisation to address female readers (or women, if gendered) in their text directly (through the use of the pronoun *you*, for instance). This, however, does not happen in the excerpt: instead, the organisation detachedly refers to 'women' and 'patients'. Lines 40-43 present both the aspects I have just described: a detached positioning of the woman, and an understanding of

her as something to be managed, hence controlled, by medical staff.

Table 14. Discourse Practice, Medical Body, Sample 1, Excerpt C: UK Professional Fertility Societies

C. Stimulating the Ovaries for IVF Treatment. "Question: What is the best drug regime to stimulate the ovaries for IVF? There is a wide range of drug regimes used, often unique to a particular clinic. In general terms, the ovaries may be switched off prior to stimulation (GnRH agonist), they are stimulated using gonadotrophins (FHS with or without LH) to make multiple follicles, which contain the extra eggs required for IVF. Measures are taken to prevent premature release of the eggs before they can be collected (GnRH agonist or antagonist)"	55 60 65 70 72

Excerpt C. Here the agent is removed throughout the answer to the question: the organisation, which consists of medical and clinical professional associations, is removing itself from the action. By doing so, the focus is kept on the female body, and the parts of it that will be passively intervened upon. This further positions the female body as both object and subject to a medical authority that is detached from the very actions it is performing.

There is a clear cue to a presupposition in this excerpt, noticeable by the opening question in line 57: *What is the best*

drug regime to stimulate the ovaries for IVF? The organisation is here taking as common sense that the reader will know that 1) there are a range of drug regimes to stimulate ovaries; 2) that these different regimes are classifiable from best to worst; and 3) that ovaries will always need to be stimulated for IVF (this is not true in the case of natural IVF, but OHSS is only a risk for women who take drugs to stimulate their ovaries). The reader is positioned as someone with some level of technical knowledge, yet in need of learning in more depth. The assumed technical knowledge includes knowing that ovaries can be stimulated via drugs, and knowing about the function of ovaries within human reproduction. The need to learn more about the topic is instead presupposed by the very existence of a series of leaflets dedicated to the explanation of medical conditions and procedures related to fertility treatment.

The use of the *definite article* further detaches parts of the female body from the prospective patient's personal experience of infertility: the question is assumed to be asked by a woman interested in knowing what the best course of action is. Yet the question is formulated as if the woman is seeing herself through the authoritative and detached medical eye: she does not ask about *her* ovaries, but *the* ovaries [lines 58 and 63], a part of her that is not her, it is other, and it is detachable and detached. The question could also be read as if it is the partner asking the question to the organisation. Nonetheless I find this process of de-personalisation of parts of the body noteworthy: the text does not say 'her ovaries' or 'the woman's ovaries', just 'the ovaries'. The organisation provides a description of a medical procedure and process that is not related to a specific person, but the question preceding the answer presupposes that it is a

specific individual interested in treatment asking the question, rather than a generalised mass audience.

Organisations thus employ the discourse of the medical body to position themselves as detached authorities in relation to the prospective patient, who is constructed as an object of the medical gaze. This subject positioning takes place through four main elements:

1. *The use of objective modality and categorical modality*. Objective modality de-personalises the action by removing the agent and separating the people involved from the action taking place. In this case, removing the agent maintains the gaze on the object of treatment. Depersonalisation is further achieved when the organisation presents questions 'synthetically' asked by the reader. It is presupposed that prospective patients would ask such questions to the organisation, yet the use of modality and presuppositions in the question entail grammatical elements found in discourses of the medical body, where the prospective patient's experience is detached, de-contextualised, and separated from treatment. When employing the discourse of the medical body, the organisation positions itself as detached from the prospective patient's body. Categorical modality is instead used to deliver legal and scientific information through short and to-the-point lists and sentences: such information is presupposed as valid and true, thus positioning the organisation as a valid authority in the field.
2. *Use of auxiliaries to prescribe behaviour*. The use of *should* and *may* are used to prescribe the organisation's behaviour with regards to the detached body it is going

to operate on. The focus is again maintained on the actions to be performed on the medical body rather than on the individual undergoing treatment.

3. Detachment is further constructed by *de-gendering* the patient, and referring to a neutral, genderless and general patient. *Neutrality* is employed to detach, depersonalise, and remove the context where infertility takes place: it is not a woman who is undergoing treatment, but a generic patient. By reading the text, the prospective patient 'becomes' the organisation and looks at himself/herself through the medical gaze, thereby becoming their own medical object.
4. *Presuppositions*. Within the discourse of the medical body there is a dual presupposition: 1) that the prospective patient has some initial level of technical and scientific knowledge with regards to treatment, and 2) that this level of acquired knowledge is insufficient for the prospective patient to understand treatment, thus more information is needed and only the organisation has the authority (already demonstrated through categorical modality) to deliver such essential technical information to the prospective patient.

6.3.2. The Distressed Body: Organisations as 'Equal' Empathisers and Bodies as Suffering 'Peers'

> *1/11/2014. Seminar given by a counsellor on alternatives to fertility treatment. The counsellor says that people will be "feeling without control". During the presentation we are shown a slide of the stages of grief (I recognised them and later checked online, but the counsellor did not introduce them as such). However, the counsellor introduces and presents all the phases as something people moving on from failed IVF go through. They say that "acknowledging **our** baggage"*

is important for people who want to move on from failed fertility treatment. Should people want to consider adoption, they caution, then they should know that "social workers will make sure that you have grieved appropriately for your loss". [Field notes, Fertility Show 2014]

The discourse of the distressed body implies emotional distress as a 'default setting' for the text consumer. The organisation constructs an emotional pain that is shared between them and the reader. The shared 'baggage' in need of acknowledgement is not only mentioned, but carefully described and contextualised: the lack of a biological child is a loss, a hope that has been taken away and lost. The organisation, as an 'equal' empathiser, grieves with the suffering 'peer' text consumer. At the same time however, it also has the capacity to name and solve this emotional pain.

Table 15. Discourse Practice, Distressed Body, Sample 1: UK Professional Fertility Societies, Leaflets

"Wherever you are treated the clinic should take your welfare very seriously and aim to provide you with an excellent service. Mostly during treatment you will see a Doctor or a Nurse however, this is not the whole picture. We believe that it is important for all concerned – you, your family and friends and for whoever treats you, to acknowledge that difficulties in trying to have a baby can be very stressful and sometimes you may feel overwhelmed. It is important to help you as much as possible to cope with the	1 5 10 15

pressures of having tests and/or treatment. For these reasons, you may want to take up the opportunity to talk to someone in confidence about how you are feeling. You may have been able to get some support from your family and friends, but sometimes it is helpful to speak to someone independent who will neither judge you nor give you advice.”	20 25 28

The modality employed here is subjective: we see this in lines 9-10, 16, 19-20, and 23-24, where the prospective patient is directly and personally addressed as ‘you’. The auxiliaries are all employed in the conditional form. Lines [1-2] (the clinic *should* take your welfare very seriously) put the organisation in a position of service and obligation toward the prospective patient. At the same time, the lines also position the organisation as an ‘equal’ empathiser who understands the importance of the patient’s wellbeing. There is no categorical modality, as the clinic is not providing facts or regulations, but options: there is no explicit authority speaking through the text, but rather an empathetic voice [see lines 16-23].

In line 2, the organisation is informing the reader that their welfare should be taken very seriously by the clinic: it is implied that, usually, clinics will look after the patient. However, the organisation is stating that the patient’s welfare should be taken *very* seriously: this contributes to a construction of infertility as a very serious matter.

Lines 7-13 present a couple of interesting presuppositions. The organisation presupposes that the patient might not

spontaneously seek counselling, and amplifies the importance of their service by extending its importance to people who are outside the organisation and indirectly related to it: family, friends, and *whoever treats you*. The informal tone – which helps position the organisation as an equal subject to the reader - nonetheless keeps the text in a familiar tone that is simultaneously authoritative. The sentence continues at line 10 [to acknowledge that difficulties in trying to have a baby can be very stressful], where the text presents cues to existing discourses on infertility: acknowledging something implies accepting that it is in fact happening, whether we like it or not. The organisation constructs the non-reproductive female body as distressed and assumes that experiencing infertility is stressful. The subsequent use of quantifiers and assertions of probability [and sometimes you may feel overwhelmed] still positions the professional association as an authority who knows that the overwhelming feeling is common among patients. This is why I call this positioning 'equal' empathiser on the organisation side, and suffering 'peer' on the woman's side: the positioning is imbalanced, but the organisation tries to convey feelings of understanding that would give the patient the idea of a balanced relation. The next paragraph in the excerpt shows how these positions are created. But first, let's notice the intertextual cue regarding the idea that having *either* tests or treatments will be stressful and require the patient *to cope with* it: not simply experience it, but cope with it.

Lines 19-23 presuppose that the reader is already suffering, and already at a stage of treatment where these overwhelming feelings are present. Again, the organisation takes as given that family and friends might have helped (but with some difficulties, in that the patient must have been *able*

to get help from them), but that is assumed not to be enough for the reader to feel better: they are still suffering, which is why *someone independent who will neither judge you nor give you advice* becomes an 'equal' empathiser – the only one that can help and truly understand all the suffering experienced by a reader positioned as 'peer'.

Table 16. Discourse Practice, Distressed Body, Sample 2: The Fertility and Gynaecology Academy, Booklet

If you are trying to conceive and have experienced recurrent IVF failure or worse, recurrent miscarriage, it can be a frightening and emotionally draining experience. At The Fertility & Gynaecology Academy we understand the frustration of couples who have experienced repeated IVF failure and have not been able to find out why it has happened or what can be done differently next time. Our clinic offers a full range of tests which aim to isolate the problems causing implantation failure, or preventing you from successfully carrying a baby to term.	1 5 10 15 18

This excerpt is about recurrent IVF failure or miscarriage, both negative experiences, particularly for people undergoing fertility treatment. It is therefore understandable that modalities and presuppositions related to the distressed body can emerge. The clinic uses the words *frightening* and *emotionally draining* in relation to the experience the paragraph is dedicated to. The use of 'we understand' [lines 7-8] has

emerged often in the data within the texts of various organisations. Whereas I would expect an informal and empathic approach from support groups and NGOs, I find interesting the permeating feature of the discourse of the distressed body in medical organisations. Organisations that would mainly employ the discourse of the medical body and maintain a detached authoritative position in relation to the prospective patient also position themselves as 'equal' empathisers that 'understand' the pain of childlessness. This is apparent through the use of the informal (and corporate) 'we' in line 7. By doing so, the authoritative feature of the organisation is softened: the organisation, while holding medical and scientific authority over the prospective patient, also constructs itself as an understanding 'equal' that *knows* how painful childlessness *must be*.

An organisation that *understands* is an organisation that feels the pain that the patient is feeling. The clinic, by abandoning medical language to describe recurrent IVF failure or miscarriage as emotionally impacting the patient, temporarily steps outside of the strictly medical domain (which has been traditionally authoritative within Western societies) to position itself as equal and empathetic toward the patient. Nonetheless, the discourse of the distressed body remains linked to the discourse of the medical body: equal becomes 'equal', in that the position of authority is maintained. The clinic 'understands', and because of this empathy, it is not only able to medically treat the patient, but is also an appropriate candidate to do so. The clinic should be treating the female non-reproductive body because it understands their emotional pain.

The section referring to patients who 'have not been able to find out why it has happened' [lines 10-12] presupposes that

other clinics were unable to be as empathic or as professional as to be able to inform the patients of what caused the medical failure. The discourse of the distressed body is the foundation onto which competition can be subtly established: the organisation is more 'equal' and more empathetic, and knows the patient is feeling distressed because they do not know what caused the recurring failures.

The line 'what can be done differently next time' [12-13] can be interpreted as constructing, through objective modality, a distributed responsibility and a balanced relation. There is no explicit agent doing things differently, the organisation is positioning itself as expert; they however do so implicitly by constructing themselves as 'equals'. This positioning could also refer to the cared for body: both the organisation and the patient will be doing something different next time in order to achieve a pregnancy. This line does not, however, presuppose mutual responsibility: rather, it detaches the organisation from the failed implantation, foetus development, or fertilisation. The clinic positions itself as 'equal' to the patient by removing the responsibility of 'doing things differently' from both. Yet, it is the patient who will be potentially feeling frightened, emotionally drained, and hence be the suffering 'peer'.

Authority is thus still maintained. The shared responsibility functions as a mask and is only apparent: the clinic is offering a service and promising an outcome, and there will be a contract between the patient (consumer) and the clinic (business and service provider). Within the discourse of the distressed body, objective modality is used to mask the inequality of the relation.

Lines 7 and 10-14 bring the organisation back to the marketplace: in line 7, the clinic refers to itself through the corporate 'we' to promote itself as a valid organisation to alleviate the pain of childlessness. The corporate 'we' personalises the organisation as someone who 'understands'. But by doing this, the clinic is positioning itself as a better service provider than other competitors in the field. In lines 13-18, the clinic 'offers a full range of tests' to alleviate the feeling of fright and emotional distress. The positioning of the organisation as 'equal' empathiser is here used to legitimise the clinic's portfolio of treatments and tests. The clinic's ability to understand the prospective patient's pain is constructed as motivating the clinic to offer their full range of tests in order to help the woman to 'successfully carry…a baby to term' [lines 17-18].

Within the discourse of the distressed body, the subject positioning of 'equal' empathiser and suffering 'peer' takes place through four elements:

1. *Subjective modality*, which includes the use of conditionals aimed at providing options rather than directions, therefore giving a sense of balance. Subjective modality is underpinned by an organisational 'understanding' of the prospective patient's emotional pain, and entails the use of informal tones: 'you' to directly address the prospective patient, and 'we' to personalise the organisation. Subject modality is used by medical and non medical organisations alike. In the case of medical organisations, they will temporarily step outside of the medical domain and abandon formal language in order to position themselves as 'equal' and empathetic to the prospective patient's situation.

2. *Objective modality*, which entails agent removal, is employed by organisations to detach themselves from failed treatment and continuation of the patient's infertile state. This creates an apparent sense of distributed responsibility and balanced relation between the organisation and the prospective patient, used to 'mask' the unequal subject positioning. Objective modality contrasts the use of subjective modality: whereas the latter is used to construct emotional pain as shared by both the organisation and the prospective patient (but it isn't), objective modality serves to position the organisation as the actor who has the ability and authority to name and terminate the distress. Thus, the organisation is not simply an equal empathic actor: its equality is only apparent.
3. The construction of *infertility as a serious and urgent issue*, whereby the organisation positions itself as an 'equal' empath having the authority to define the emotional state behind infertility. This is done through the use of *quantifiers and probabilities* to convey authoritative knowledge of the feelings of distress the prospective patient might experience.
4. A number of *presuppositions,* such as assuming patients will not spontaneously seek help outside medical treatment (counselling, therapy), even though they should (as infertility is a serious and urgent issue, as noted in the point above). A second presupposition assumes the prospective patient as already in a state of emotional suffering; third, that family and friends will not be enough to support the prospective patient in their pain, thus the organisation is needed throughout the patient's journey. Fourth, organisations presuppose that

the more empathic the organisation is, the better suited it will be to treat and deal with the prospective patient. It is a presupposition that subtly hints at competition in the marketplace: because they *really* understand the emotional pain of childlessness, organisations position themselves as better candidates with respect to their competitors.

6.3.3. The Cared for Body: Organisations as Parents and Bodies as Children

> *"The best thing you can do is to be as well informed as you can."*
> *"Do your homework!"*
> *"Be kind to yourself."*
> *"Don't expect to understand everything."*
> [Quotes from seminar given by an IN UK representative – Field notes, Fertility Show 2014]

The discourse of the cared for body constructs the female non-reproductive body as in need of care, and in need of learning to take care of itself. It also constructs a sense of being in control of the situation the prospective patient is finding themselves in by gathering information, 'doing their homework' and evaluating expectations with respect to treatment. Within this discourse, the organisation positions itself as a figure that knows what is best for the prospective patient, be it a form of care or self-care.

I call this subject positioning parent/child because of the duality of expectations emerging within the discourse of the cared for body, which is similar to the relation of a parent with their child. The parent (organisation) will take care of the child in various ways, just like organisations do in relation to the prospective patient. At the same time, the parent will also expect the child to grow, be proactive, and take care of

themselves, just like organisations in the field expect prospective patients to gather information, manage their lifestyle (and eventually amend it), and self-manage as to increase their chances to conceive.

Table 17. Discourse Practice, Cared for Body, Sample 1: The Fertility and Gynaecology Academy, Clinic Booklet

Excerpt A A Consultation to explain the results follows. Here at the Academy we take the proper time and care to ensure that you are informed and fully understand the implications of any test results. You will have the opportunity to ask any questions and receive comprehensive answers in plain English so you're never kept in the dark. *Excerpt B* At The Fertility and Gynaecology Academy we make things as simple as possible, offering our patients a comprehensive Fertility Check to make sure all is well. For one upfront fee, you will receive a comprehensive assessment of your fertility potential, and, if any potential stumbling blocks are discovered, we'll guide you around the next steps. 1. In an Initial Consultation with one of our esteemed fertility experts, we'll talk you through the whole series of necessary tests, through which you'll have an expert consultant as your port of call. You'll also have the chance to have your questions answered.	1 5 10 15 20 25 28

The modality in the above excerpts is subjective: in lines 5-6 it takes a patronising form of care; in lines 19-20 and 22-26 the auxiliary 'will' is used as promise and commitment to taking care of the prospective patient.

Excerpts A and *B* present the presupposition that results need to be explained: the prospective patient is not expected to have the knowledge or the medical expertise [lines 6-7, 12-13 and 23-25]. In lines 2-5 ['we take the proper time and care to ensure that you are informed and fully understand the implications of any test results'] the organisation is giving 'proper' time and care to the patient: they are aware that the delivery of scientific/medical results to 'lay' people will need not only time, but 'proper' time and care. The organisational aim here is not only to present and explain results, but to empower the patient so that they fully understand. The organisation takes care of the patient by teaching them, guiding them through their results, but also by empowering them so that they can take care of themselves. However, the organisation maintains a parental positioning by telling the reader how to take care of themselves (by asking questions and making sure they know what they are doing at the clinic) [lines 12-13 and 19-20].

As mentioned above, I call this relation parent/child because the analysis of modality and presuppositions reflects the discourse of the cared for body in a way that is similar to how a parent will relate to a child: by taking care of them, but at the same time by expecting the child to learn. This child is also understood as relatively young: answers will be given in 'plain English', and will be guided through the next steps [lines 19-20]. The organisation is, further, almost a generous parent, in that they will give 'the chance' to the patient to have their

questions answered [lines 26-28]. It is presupposed that this chance is not usually given by other clinics: were they to refer to other clinics for their treatment, patients would not learn as much about themselves as they do thanks to this specific clinic.

Table 18. Discourse Practice, Cared for Body, Sample 2: HFEA, Booklet

IVF treatment is stressful. The science and medicine involved can be confusing and intimidating, and patients often feel uneasy about asking too many questions. It is important to make sure that you share your thoughts and anxieties with the doctors and nurses treating you. Making decisions together and understanding the reasons of your choices will help you get the most out of your treatment.	1 5 10

This excerpt from the HFEA booklet represents a quote from a medical professional on the doctor-patient interaction. The main presupposition is that treatment is stressful, a feature I have already presented when discussing the subject positioning related to the discourse of the distressed body. What positions the organisation as a parent is its speaking *on behalf of the patient* by stressing how 'patients often feel uneasy about asking too many questions' [lines 4-5], and how 'It is important to make sure that you share your thoughts and anxieties' [lines 5-7].

Scientific knowledge is, again, acknowledged as being confusing and intimidating [lines 1-3] and patients might be overwhelmed by it [4-5]. This already positions the organisation

in a wise parental position that wants to make sure that the child (patient) feels comfortable to share their anxieties in order to learn and understand the various treatments and procedures. The child needs to understand that asking questions will ultimately benefit them. The organisation is caring for the patient by teaching them how to take care of themselves and being more in control of their present and future situation.

Further, the acknowledgement of confusion and intimidation is strongly tied to the (lack of) knowledge that patients have, much like unprepared children. This presupposition emerged often in my observations while attending seminars at the Show both in 2013 and 2014: speakers will remind the attendees to 'do their homework' and gather as much information as possible on fertility-related legislation, treatment, and support. The presupposition is that the organisation will help, but only until a certain point: the text consumer will have to do their part for a successful outcome to be achieved.

Within the discourse of the cared for body, the organisation will position itself as a parent while simultaneously positioning the prospective patient as a child through subjective modality and presuppositions. Specifically:

1. *Subjective modality* is employed to create a familiar sense of care given by the organisation. The use of the auxiliary 'will' suggests organisational commitment to taking care of the prospective patient.

2. Through the *presuppositions* that a) treatment is stressful and scientific knowledge is intimidating; b) that the prospective patient needs to be in control of some of the process in order to reduce this intimidation, thus it is

encouraged to be proactive through self-care; c) even when partly in control of the process, prospective patients will still need organisational care in the form of teaching and supporting rather than just medical treatment; d) that the organisation that provides more care to the prospective patient will be the most suitable against competitors in the market.

6.4. Creating the Need for Organisational Intervention in the Female Non-Reproductive Body

The three relations presented in this chapter have one crucial element in common – within each of the discourses of the body emerging in chapter 5, organisations create a sense that organisational intervention is *needed* by the prospective patient.

Within the discourse of the medical body, the organisation is needed as a detached authority to detachedly examine and fix the prospective patient's body: because no context is needed or provided to infertility, the need to be addressed is strictly medical. There is a condition that has to be fixed and cured by the organisation, thus significance is given to the best organisation that can do so. In this regard, empathy or care are not regarded as important factors; rather, scientific knowledge, authority, and competence are.

Within the discourse of the distressed body, the organisation is needed as an 'equal' empathiser. The stress is on the assumed emotional pain caused by childlessness, and the organisational ability to truly understand it and help relieve the prospective patient from it. A personalised approach is thus necessary, in that establishing an empathic relation is the first step for the organisation to 1) establish that there is emotional pain; 2) that this emotional pain needs to be relieved; 3) that organisational intervention is needed to relieve such distress;

and 4) that the organisation that best acknowledges these points is the best suited to provide its services and products to the prospective patient.

Within the discourse of the cared for body the organisation is positioned as a parental figure towards the prospective patient. As a parent, the organisation sets expectations on both itself (care) and the prospective patient (self-care, control) as a child. The organisation is needed to establish what expectations are to be had in relation to treatment: what the organisation has to provide, and what the prospective patient will have to expect and do to be successful. In this case, the organisation most prepared to provide care and teach the prospective patient about self-care will be seen as the parent most competent to raise the child.

6.5. Conclusion

In this chapter I examined how organisations use discourses of the non-reproductive female body at the Fertility Show to construct themselves in relation to it. I showed how each discourse entails a relation where the organisation positions itself as needed with regards to the prospective patient. I discussed how subject positioning takes place in organisational texts through what Fairclough calls 'synthetic personalization' (1989/2001: 52): in order to build a relation with prospective patients attending the Fertility Show, organisations will synthetically create individuals from mass audiences (6.2). Such 'synthetic personalization' is needed in order for organisations to establish a relation where subject positioning can take place. I then presented how through subject positioning relations are constructed to each of the three discourses of the body presented in chapter 5 (6.3). Specifically, the discourse of the medical body engenders a

relation that constructs the organisation as a detached authority and the prospective patient as an object to be examined and fixed (6.3.1). The discourse of the distressed body constructs the organisation as an 'equal' empathiser and the prospective patient as a suffering 'peer'. The organisation knows and understands how the prospective patient might feel, and is needed to alleviate the emotional pain deriving from childlessness (6.3.2). Finally, the discourse of the cared for body gives rise to the relation that sees the organisation undertaking a parental role with regards to the prospective patient, who is in turn seen as a child. The prospective patient is positioned as a child in need of being taken care of by the organisation, but also in need of learning from the organisation how to take care of themselves (6.3.3). In section 6.4 I notice how each relation constructs the organisation as needed by the prospective patient. The need to be addressed varies depending on the discourse of the body the organisation is drawing upon in their texts: it will be a need to solve a medical problem within the discourse of the medical body; a need to alleviate emotional pain within the discourse of the distressed body; and a need to set expectations and to be cared for within the discourse of the cared for body.

In the next chapter I present the social practice level of analysis, and thus discuss how the discourses emerging in chapter 5 and the relations emerging in this chapter contribute to maintaining field legitimacy at the Fertility Show. Specifically, for each body and relation I identify historical and social discourses that influence current organisational constructions at the FCE and provide insights into their legitimacy.

CHAPTER 7. SOCIAL PRACTICE: BODIES, RELATIONS, AND THE MAINTENANCE OF FIELD LEGITIMACY

7.1. Introduction

In chapter 3 I showed how from 1978 the field of fertility treatment emerged and developed through the increased public anxiety following the birth of the first test tube baby. Regulation towards clinics and the delivery of fertility treatment increased and much public debate arose to make sure that the creation of life, had it to happen in non-natural ways, had to at least be conducted in the most ethical fashion. Great emphasis was given to the status of the embryo rather than on the female body per se. In chapter 5 I presented the findings of text analysis, and showed that today organisations at the Fertility Show construct the body as medical, distressed, and in need of care. In chapter 6 I presented the findings of discourse practice, and showed how each discourse is employed by organisations to create relations between themselves and the female non-reproductive body.

This chapter presents the social practice level of analysis, and answers the question: *How are the constructed bodies and relations maintaining field legitimacy at the FCE?*

Rather than introducing new data, I here provide a further level of data interpretation and contextualisation. The purpose of social practice is to contextualise the discourses and relations that emerged in chapters 5 and 6. I aim to understand if and how social discourses existing *prior* field emergence contribute to maintaining field legitimacy today at the FCE. In order to do so, I analyse secondary data to historically contextualise the findings from text analysis and discourse practice. Rather than further analysing data collected at the Show, in this level of analysis I employ additional contextual references on the

female body and the history of reproductive medicine, and interpret them together with the results emerging from chapters 5 and 6.

The social practice level of analysis shows how field legitimacy, that seemed to explicitly emerge in 1978, is in fact rising from previously established discourses on both the potential future life and on the female reproductive body; these discourses further underpin the bodies and relations emerging in chapters 5 and 6. Each body and relation constructed today at the Fertility Show in turn maintains pragmatic, moral, and cognitive legitimacy. As presented in section 2.2, legitimacy is the "acceptance of the organization by its environment" (Kostova and Zaheer, 1999: 64). Suchman (1995) distinguishes three types of legitimacy: pragmatic, moral, and cognitive. *Pragmatic legitimacy* is "the self-interested calculations of an organization's most immediate audiences" (1995: 579), whereas *moral legitimacy* has to do with 'doing what is right' and is based on normative evaluations of the organisation's activities. Moral legitimacy can be based on comprehensibility or taken-for-grantedness. *Cognitive legitimacy* is based on the understanding of the organisation as inevitable or necessary based on unquestioned and taken-for-granted social norms. Cognitive legitimacy can be *consequential* or *procedural* (see section 2.2).

The chapter presents the pre-existing discourses currently informing the medical body and the detached authority/object relation (7.2); the ones informing the distressed body and the 'equal' empathiser/suffering 'peer' relation (7.3) and past discourses informing the cared for body and the parent/child relation (7.4). Based on the outcomes of this level of analysis, the chapter further discusses how pragmatic, moral, and cognitive legitimacy of each body and relation is maintained

(7.5), and proceeds to present the strategies of reiteration, adaptation, and interruption (7.6) before concluding (7.7).

7.2. Legitimising the Medical Body

The construction of the medical body is rooted in historical discourses that understood the female body as a wife and mother first, and thus as a vessel to be intervened upon in order to reproduce. Historically, medicine was responsible for preserving female fertility; indeed, it was only in the late 1970s that concerns about sterility gained public attention. Nonetheless, medicine maintained authority over women's fertility: if not to preserve it, the medical establishment had to restore it or achieve it. The medical body is constructed by all organisations at the Fertility Show; however, in line with the historical discourses presented in this section, it is a construction that mostly emerges within the texts of medical and governmental organisations.

This section illustrates how the female body is still considered an object to be intervened upon by organisations within the field. It further discusses how, in order to maintain legitimacy, organisations are both adapting to current social norms and reiterating past discourses on the female body.

7.2.1. Historical Links to the Construction of the Medical Body and the Detached Authority/Object Relation

Within this relation, the object of the female body appears linked to Victorian medical discourses of normalcy and deviance largely deriving from social norms on women. Towards the late nineteenth and early twentieth centuries, doctors classified women in relation to their reproductive capacity on the basis of a set of categories that established what a 'normal' woman should physically look like, and how she should behave (Terry and Urla, 1995; Gallagher and Laqueur, 1987). In this sense, a

female body which could not or did not reproduce was abnormal and deviant, however both a woman who gave birth to triplets and an involuntarily childless woman would have been categorised as "deviants and victims of abnormal sexual health" (Pfeffer, 1993: 31).

Within gynaecology, what constituted a 'normal woman' was largely defined by the work of a Victorian physician named J. Matthews Duncan (1826-1890), who identified and described the characteristics and conditions under which a woman is considered fertile: from those sets of conditions he then derived the deviations from the norms he established and that would make the woman infertile (Duncan, 1884). Within the works of Duncan, references and comparisons to the animal kingdom abound: in his work on female sterility informed by Darwin's work, Duncan begins by portraying causes of sterility in plants, in animals, and among wild and domesticated animals and further compares them to instances of human female sterility (Duncan, 1884). He also notes a link between sterility and women's external reproductive organs, what they looked like, as well as their 'imperfect development' in women who sought sexual pleasure without reproduction (1884: 97). In this regard, there was an important connection made by the medical profession between a woman's physical health and her mental health. A female body who would not reproduce must have been home to an unhealthy mind. Herman's key work *Diseases of Women* (1907) stresses the importance of women's "reproductive function" (1907: 2) in relation to their happiness.

He stresses,

> "The greatest happiness and highest aspirations of most women are in marriage and maternity. For the average woman a disease which unfits her to be a wife or a mother is the greatest misfortune that can happen to her, next to one which threatens her life. Hence diseases which in themselves only cause trifling suffering have an importance out of proportion to their effects on health if they tend to unfit the patient for marriage and maternity" (Herman, 1907: 2)

The medical discourse on the female reproductive body was thus encased in broader concerns for the woman's primary functions within society – that of wife and mother. It was also a discourse that implied that an infertile marriage was an unhappy one, and that infertility could be comparable to a life-threatening event for a woman; the potential future life was prioritised on behalf of the infertile woman. An infertile female body meant an infertile mind, too: a woman's reproductive system was understood as in interaction with her brain, thus establishing her mental health was an essential step in being able to diagnose sterility. Psychiatry played a key role in this process, and gynaecological procedures were often used to treat women's mental disorders (Pfeffer, 1993). Mind and body were hierarchically organised: the mind controlled the body, and reason controlled emotion. Hence mental disorders in women "led to gynaecological pathology and gynaecological pathology made women mad" (Pfeffer, 1993: 34). Within this understanding of the mind as above and in control of the body, the sexes became represented as incommensurable (Laqueur, 1987) yet interdependent: male and female became opposite representations of culture and nature, yet with set roles in

society. Laqueur points out how this representation, despite originating from science, was closely tied to political agendas from the eighteenth century onwards, when "[w]riters… sought in the facts of biology a justification for cultural and political differences between the sexes" (1987: 18), thus placing the female body in particular as the main locus where women's social and political status was to be inscribed (Laqueur, 1987: 30; see also Soloway, 1995).

Further, the construction of organisations as detached authorities can be traced to the social reactions to medical, professional, and social developments within reproductive medicine and rights. When Marie Stopes and the Malthusian League opened the first birth control clinics in the early 1920s, they were met with hostility by both the medical profession and religious figures, particularly Catholics (Leathard, 1980). Doctors initially stood against birth control for two reasons: they lacked knowledge in reproductive medicine, and were influenced by Christian morality. Embracing the practice of birth control meant associating with doctrines and principles that were at the time vastly considered "disreputable" (Leathard, 1980: 2). There was, however, perhaps a more relevant factor to consider when it came to the attitude of the medical profession towards women's health: competition. In fact, if the sanctity of motherhood were to be respected, doctors performing ovariotomies started to be seen as a danger to what was most precious in a woman's body – her sexual and reproductive organs that would have made her a mother. It was in the early 1900s that gynaecologists began to present themselves as "champions of fertility" (Pfeffer, 1993: 42), against the insufficiently trained hands of general surgeons. An infertile woman was more likely to give birth to a child thanks

to skilled gynaecologists, due to their attitude towards conservation of the woman's organs rather than their removal. In this respect, during the interwar period, the British College of Obstetricians and Gynaecologists was created. The College's existence was justified by not only the general expertise of gynaecologists in the preservation of women's fertility, but also by the experience of obstetricians in assisting women in labour (Pfeffer, 1993; Oakley, 1984). Once again, the medical establishment gained authority in relation to its ability to preserve women's fertility, and motherhood was the focal point of concern.

With regards to the inability to conceive, however, investigations on medical infertility did not initially originate from the medical profession or the government, but from NGOs. The National Birth Control Council, founded in 1930 with the merging of five birth control clinics, changed its name to Family Planning Association (FPA) in 1939 (FPA, 2011). As a voluntary organisation, the FPA worked at a distance from the medical establishment; however, it was the Association that towards the end of the 1930s began to provide treatments for sterility among the services available at its clinics (FPA, 2011). This was not welcomed by the College: instead, the FPA's activities were seen as casting a bad light on the vast majority of British hospitals that were not as up to date with modern approaches to infertility screenings and treatments (Pfeffer, 1993).

The British government abstained from intervening in the matter until the 1980s with the meeting of the Warnock Committee: up until then infertility was mostly talked about in public, and most of the political concerns related to population control and health concerns in relation to maternal and child health (see chapter 3). This, however, left doctors with considerable margins of intervention on infertile women's

bodies without any official regulations or restrictions: indeed, "[t]he only restrictions on medical practice have been professional considerations" (Pfeffer, 1993: 94).

After the Second World War, not much had changed for women. The National Health Service, founded in 1948, provided free medical care for everyone; however, social reforms taking place after the war only reinforced the conception that a married woman's reproductive life was her husband's business. Up until the post war period, the female reproductive and non-reproductive body had been a man's responsibility, be it a father, a husband, or a medical professional. The British government abstained from intervening, especially during peace time when international politics concerns in relation to population were lower (Lovenduski and Outshoorn, 1986). This situation changed after 1978 when infertility emerged almost as a new disease for which the government had not prepared the population. The market had, however, been preparing for a few decades and was now ready to intervene on women's bodies to alleviate their social dysfunction.

7.2.2. Present Traces of Past Discourses: Object Bodies and Detached Authorities

The analysis presented in chapters 5 and 6 showed how the female body is still constructed as *a thing* to be intervened upon by medicine in order to become a mother.

In chapter 5, I showed how this construction of the body as an object is done through the fragmentation and examination of body parts (see section 5.3), and by constructing the body as a separate entity from the individual and emotional experience of treatment. The purpose of treatment is, of course, the live birth of a child. However, unlike in Victorian times, this is not so much because a marriage is

fruitless without children – nowadays single women and unmarried couples can have children too – but rather because a woman's life itself is incomplete without a child. Organisations today understand that marriage is not a social necessity any more, but motherhood is still constructed as such.

The detached authority/object relation is in turn maintained as legitimate by this underlying social aim of motherhood. This is possible because organisations within the field and at the FCE are simultaneously taking part in two dynamics: 1) by not restricting access to their products and services to married couples and by welcoming single women and both heterosexual and homosexual unmarried couples, organisations are adapting to the current social environment that does not prioritise marriage over childbirth; 2) by constructing the female body as an object to be intervened upon in order to achieve the status of motherhood, organisations are reiterating past social discourses on woman's maternal role in society.

The construction of the body-object reiterates medicine's historical decisional power over what is medically and socially normal or deviant, as well as the historical removal of agency from the female body. These emerge from the analysis I presented in chapters 5 and 6. In chapter 5 I showed how the body is assumed to be medically dysfunctional, and that the power to name disorders and dysfunctions is in the hands of organisations. In chapter 6, I showed how organisations position themselves as detached authorities: their relation of authority with regards to the object body is constructed through objective and categorical modality that make organisations the authoritative knowers of scientific facts.

Another important organisation in this picture is represented by the British government. If on one hand the medical establishment historically had the task of maintaining women's fertility due to social expectations of motherhood, on the other hand the British government refrained from regulating fertility treatment until the 1980s, thus allowing the private sector to flourish. The UK government only became active with regards to infertility treatment from 1978, when concerns about the ethics of the embryo arose with regards to treatment (chapter 4). At this time, the woman's body was implicitly conceived as a vessel, barely mentioned in governmental documents related to the field of fertility treatment, or only referred to as a mother.

Within fertility treatment, the government's late intervention provided the field with a level of pragmatic legitimacy, and had the double effect of:

1. raising the status of medical and profit-driven organisations as authorities that can intervene on the female non-reproductive body due to their being present in the field longer than the government. This happened in a competitive environment that flourished and allowed organisations to gain strong positions by virtue of being better suited to intervene on the female body than their competitors;
2. constructing organisations as authorities that are detached from the female body. They are detached from it both *temporally*, in that legally the government only started to publicly discuss issues related to reproductive technologies from 1978, and *de facto*, in that organisations had mostly been concerned with the potential future life rather than with the female body per se.

The construction of the relation that positions the organisation as a detached authority can further be explained by noticing how reproductive medicine experts constructed themselves as 'champions of fertility' and thus exercised their authority primarily to *maintain* fertility. This is still present, but instead of maintaining fertility, organisations in the field are curing the absence of it. The means and focus are different (fertility boosting instead of control and limitation, through for instance ovulation inducing drugs rather than birth control) but the aim has not changed. Again, legitimacy is maintained by adapting to society's needs (the need to cure infertility) and by simultaneously employing pre-existing discourses that reiterate organisations' legitimacy in relation to the female body (the non-reproductive body needs to become reproductive). The need for a detached authority to examine and cure the non-fertile body is still present, in that the need for an offspring is still constructed as paramount.

Text analysis and discourse practice show that organisations are still positioning themselves as champions of fertility, particularly within the marketplace. When constructing the body as medical, organisations construct themselves as the best authorities who can test, diagnose, and cure the absence of fertility. This is in contrast for instance to a number of organisations at the periphery of the field that encourage adoption and fostering as alternatives to treatment.

Discourse practice showed how organisations create relations with the female medical body by establishing themselves as better authorities than their competitors to act upon its infertility. This relation carries historical traces of the late arrival of governmental intervention on fertility treatment, which consequently allowed for the marketplace to occupy the largest section of the field (and of the FCE) to this day, and for

competition to be a tool for organisations' authority over the female non-reproductive body.

7.3. Legitimising the Distressed Body

Within the discourse of the distressed body, organisations construct themselves as 'equal' empathisers and the body as a suffering 'peer'. I have mentioned above how the discourse of the medical body encourages the construction of the distressed body and draws from a medical tradition that argued that a woman's happiness depended on her ability to become a mother (see section 7.2.1).

The discourse of the distressed body links back to historical discourses on motherhood widely embraced by British society: even the women's movement, despite advancing women's political and economic rights, did not contest women's maternal role within society until the late 1960s. Rather, such a role became the subject of increased control through contraception: because women naturally desired motherhood, birth control would have helped them time the births of their children. Today, the discourse of the distressed body is mostly employed within the field by the same types of organisations that in the past worked for the advancement of women's rights and the provision of birth control services. NGOs, clinics, and fertility-related businesses all employ this discourse at the FCE to maintain legitimacy.

The next section discusses the historical importance given to motherhood and marriage within a woman's life, and the mutual efforts of Marie Stopes and the suffragettes in promoting women's reproductive health. Whereas both played fundamental roles in the advancement of women's rights and reproductive health, none of them effectively contested the social assumption that a childless woman would necessarily

suffer. As a result, other discourses have historically been prioritised over the woman's body: where once eugenicist and political interests took central stage with regards to reproductive medicine, today the priority at the FCE and in the field is given to the future life rather than the woman's body.

Thus, the female body still comes second, this time to the potential future life, whose absence is assumed to cause emotional suffering that can only be relieved through organisational intervention.

7.3.1. Historical Links to the Construction of the 'Equal' Empathiser and Suffering 'Peer' Relation: Between Eugenics and Feminism

The importance of motherhood and marriage have seldom been questioned in the past within reproduction and reproductive medicine. With regards to reproductive medicine and its early developments, marriage and motherhood were initially not contested by feminists: implicitly, motherhood within marriage was any woman's desire and what would make her happy. This came largely from medicine (section 7.2.1) but was not questioned by feminists until the late 1960s and 1970s. Indeed, it was still not significantly questioned within discussions related to the first IVF baby in 1978 (chapter 3). The attitude of the women's movement during the first half of the twentieth century is an exemplary case of the social taken-for-grantedness of childlessness as a painful experience for women.

Social attention to women's role in British society started to increase towards the end of the eighteenth century. During this time, Female Friendly Societies had risen with the aim to financially help women gain some degree of economic independence from their husbands (Hill, 1989). The social belief

that a woman only existed in relation to marriage or to prostitution changed during the nineteenth century, when advances in reproductive rights and medicine were made available to married and unmarried women alike. However, the social preoccupation with women's reproductive lives was greatly related to the eugenicist need to control the population's racial stock rather than to foster women's reproductive autonomy (Pfeffer, 1993; Kevles, 1986). This is evident by briefly examining the main historical developments of birth control in the UK through the important figure of Marie Stopes. By playing at the interface of British eugenicist elites and the feminist movement, Stopes represents a clear example of how the assumed pain of childlessness (or of happiness only to be found in one's biological children) was unchallenged even when both science and feminism declared that, thanks to birth control, important steps toward women's liberation had been taken.

A key organisation in delivering education to the British population on birth control was the Malthusian League, founded in 1877 and in contact with the women's movement through the figure of Marie Stopes. Stopes was not part of the feminist movement, but her involvement with the suffragettes allowed for broader public discussions on reproduction to take place, in line with the political and civil achievements of the women's movement after the First World War. Suffragettes used such momentum to work with Marie Stopes in the opening of birth control clinics and in publicly breaking the taboo of sex and reproduction within the family (Leathard, 1980). Birth control was one of the ways feminists had to have control over reproduction and their own bodies, hence to be able to be workers and be recognised as citizens. Stopes, however, had little to do with the women's movement up until then. Rather,

her interest lay within eugenics, but the relation with the feminists offered mutual benefits: Stopes aimed for more selection with regards to human reproduction within the population, whereas feminists pushed for more control for women over their own bodies so that they could have a place in public life. Leathard (1980) argues that was but a natural development for the women's movement once the vote had been secured.

The historical intertwinement of eugenicist interests with the advancement of women's rights is a relevant factor for the underpinning unquestioned assumption of motherhood and marriage within reproductive medicine until 1978. In fact, Stopes was largely responsible for the opening of birth control clinics, but she still advocated birth control *within marriage*. Birth control was to space out children, not to avoid them altogether. In 1921, Stopes founded the Mothers' Clinic for Constructive Birth Control, which was the UK's first birth control clinic. In the same year, she also founded the Society for Constructive Birth Control and Racial Progress, of which she was President. The aim of the Society was to continue to push for birth control while at the same time stressing the "sacredness of motherhood" (Leathard, 1980: 13). Stopes was notoriously in favour of using sterilisation on those unfit to become parents (Cohen, 1993), however her ideas of fostering racial progress through such procedure lacked support and thus pushed her back to supporting birth control for the same purpose (Leathard, 1980).

It is worth remembering that in its early days, the birth control movement was aimed at married women only: this is reflected in one of Stopes' more famous books, *Married Love* (1921), where she stressed the importance of sexual relationships within the married couple. Thus, fertility was still

encouraged within marriage, so that when fertility treatment became available, it was coming from a historical background where any medical intervention over reproduction (either for control or to relieve sterility) was viewed in light of the sacredness of motherhood within marriage.

Eugenicist and feminist interests were travelling on parallel lines during reproductive medicine's early developments. The interests of the suffragette movement primarily lay within political rights, and only later joined Stopes' efforts as a way to grant some form of reproductive control to women who had fought to remain workers after the war. On the other hand, Stopes herself was not particularly interested in granting women reproductive autonomy. Rather, her aim was to provide women with some degree of control over birth timings within marriage: an interest that was in turn tightly linked to her active role among the UK's eugenicist elites. The cooperation between Stopes and the feminists flourished with the opening of the first birth control clinics, but those were nonetheless initially only intended for married women, and stressed the importance of motherhood.

We can thus notice how, historically, political and eugenicist interests took an overall priority over women's reproductive autonomy. Outside of medicine, motherhood was still prioritised within British society for two reasons: 1) because it went largely unchallenged by the women's movement itself, and 2) because it was primarily seen as a fundamental political tool to manage and control British population.

7.3.2. Present Traces of Past Discourses: Happiness Lies Within the Potential Future Child

In chapters 5 and 6 I showed how the construction of the distressed body places emotional suffering within the

experience of infertility. The distress is thus not limited to a medical condition, but it applies to a social one: rather than medical infertility, the cause of the suffering is the absence of the status of motherhood.

Within the field of fertility treatment, the social call for motherhood is still not questioned. Whereas this can come by no means as a surprise given the nature of the field, it is worth noting the complete lack of references, mentions, documents, and materials indicating that a childless life can be a happy one. There is, however, an initiative part of IN UK called "More to Life", dedicated to supporting the involuntarily childless by focusing on how a life without children can be lived happily. Nonetheless, this was not publicly presented or discussed at the Fertility Show. I take this as a significant message, particularly given the acknowledged importance of FCEs with regards to field configuration (Lampel and Meyer, 2008; Wooten and Hoffman, 2016). Furthermore, apart from the initiative's logo inside IN UK's magazine issues, there are no mentions of the initiative and no space is given to make women who are just approaching the FCE as a prospective patient feel 'normal' even if infertile or non-reproductive. This strengthens the construction of the organisation as an 'equal' empathiser: if a life without children cannot be lived happily and the female body is constantly reminded of her pain by someone who 'understands', then the underlying assumption of the necessity of motherhood is strengthened and justified. Within the field, the only way to be happy is to seek organisational intervention so that the female non-reproductive body can become a mother.

The idea that *women can only be happy when mothers* has gone unchallenged before, during, and post field emergence, and is employed by organisations at the Fertility Show to

maintain legitimacy: before field emergence, women's role in society was that of both wives and mothers, and reproductive medicine only served the purpose of fulfilling the natural and social call of motherhood that would have made their marriage complete. After field emergence and with the development of the field of fertility treatment, women did not necessarily need to be wives, but motherhood was (and is) still constructed as a natural desire for the woman. The concept of the sacredness of motherhood within a healthy marriage was abandoned, only to be substituted by the importance of potential children through the discourse of the distressed body.

The potential future life thus gathers priority over the woman's life, which fosters the understanding of an infertile body as distressed. Rather than being in distress because unable to make their marriage complete and thus become happy (before field emergence), childless women are now in distress first and foremost because they are unable to turn the potential future life (which would make them happy) into a reality. This is most evident through the personification of future life I presented in section 5.5.3: women are 'special' first and foremost because they should be able to naturally become mothers.

The personification of the future life against the de-personification of the female body within the field is linked to the relation of the organisation as 'equal' empathiser and the female body as a suffering 'peer': the assumed emotional pain justifies an understanding of the female non-reproductive body as naturally wanting to become a mother and needing to do so. Organisations know and 'understand' this longing and will use empathetic language to support the female non-reproductive body in their journey towards motherhood (see for instance organisations stating that 'age is unkind to women', as quoted

in section 5.5.3). Organisations are needed to plan a family and to make the personified potential future life a reality, and thus to relieve the distressed body from its emotional pain.

7.4. Legitimising the Cared for Body

The cared for body engenders a relation of parent and child between organisations and the female body. This section discusses the reasons underlying the construction of the cared for body and of the parent/child relation. The socio-historical factors emerging from social practice analysis are the stress on the management of reproduction and the taboo of infertility, which are in turn historically grounded on the concepts of maternalism and family building. I first present considerations on the management of reproduction required by the parent/child relation.

7.4.1. Construction of the Parent/Child Relation: Considerations for Social Practice

The emergence of the parent/child relation is linked to discourses on the importance of the management of reproduction, which in turn point to the individual responsibility of the prospective patient in relation to the possible treatment outcome. Within the field and at the FCE, the reproductive process is carefully managed, and necessarily so: from tests and diagnoses, to treatments and counselling, organisations construct their presence as organised, organising, and managing. These traits can be noted both within the discourse of the cared for body and within the parent/child relation.

In section 5.6.4 I noted how practices of care and self-care are closely tied together and construct a body that is under constant monitoring and management. Importantly, practices of (self-)monitoring and (self-)management need to happen not

only with regards to the medical side of fertility treatment, but also in relation to the prospective patient's lifestyle, habits, and daily routines. In section 6.4 I argued that by constructing themselves as parental figures towards the body, organisations set expectations on both themselves and on the prospective patient. Thus even when the prospective patient is expected to have a certain degree of agency, this is only 'activated' by the organisation, which will tell the prospective patient how to take care of themselves and how to ask for help, or what the best routes are to being taken care of. There is, overall, an organisational management of the prospective patient's agency.

At the FCE, the importance of managing reproduction sustains the taboo of infertility outside of the event and the field, but 'breaks' it continuously and temporarily within the FCE. I presented examples of infertility being kept secret by women (chapter 3), as being socially constructed as a taboo (section 4.8), and as hard to understand for those who do not experience it (see chapter 5).

By constructing themselves as authoritative, empathic, and as parental figures, organisations at the FCE shape the field as a set of organisations to which it is okay to open up about infertility: not only do they *know* what infertility is and what it may *feel* like, but they also *understand* it. Within the field, infertility can and should be openly discussed; this is in contrast to the social environment outside of the field, where the inability to have children is acknowledged by organisations themselves as something patients may have troubles discussing (see chapters 5 and 6). More importantly, inside the field infertility should be discussed in order to be managed, because only a well (self-)managed life can increase the chances of having a

child (and thus of getting rid of the taboo outside of the field too).

Organisations hence construct the body as in constant need to be cared for, and themselves as the best ones to do so. This is not surprising, in that any organisation in any field will need to maintain some level of legitimacy in order to operate (Shocker and Sethi, 1974). However, there are two distinguishing features of the field of fertility treatment to consider: 1) it is a field entailing a central focus on the very material essence of the body; 2) its core issue, infertility, is considered a taboo within Western societies (Whiteford and Gonzalez, 1995; Thorn, 2009; Becker and Nachtigall, 1992; Nachtigall et al., 1997; Gannon et al., 2004). These two points allow for organisations to gain considerable importance within the prospective patient's life – a life that, as mentioned above, will need interventions throughout if chances of a live birth are to increase.

However, the importance of the organisation in the female body's life, which is encompassing, is also partly separated from the responsibility for possible treatment outcomes, which is constructed as shared expectations in the parent/child relation (section 6.3.3). Organisations in the field will in fact construct different expectations prospective patients should set both on themselves (as children needing to learn their best behaviours) and on the organisations (as parents who will tell the child both what behaviour to have, and what they should expect from a good parent/organisation) so as to better manage their lives, and thus increase their chances of live births.

If responsibility is constructed as shared between the organisation and the female non-reproductive body, then the consumeristic nature of fertility treatment becomes difficult to

challenge: the female non-reproductive body is partly responsible for the poor management of its reproductive life, maybe because it did not buy the right service or product to take care of its condition. It might have not taken adequate care of its diet, or did not manage its stress adequately. Within a field vastly constituted by profit-driven organisations, the choices made by the female body to buy a particular product or a service to alleviate its infertility are a reflection of its responsibility towards the possible treatment outcomes.

At the Fertility Show and in the field, the female body can, and is expected to, talk about and discuss its problems, be they medical, emotional, or related to the management of its day-to-day lives. At the same time, organisations understand and empathise with prospective patients and make sure that they know that organisational presence throughout the journey of fertility treatment will be constant and solid. At the Fertility Show, the taboo of infertility is temporarily broken, but is nonetheless maintained outside of the field. When maintained, the taboo fosters the sense of shared responsibility while at the same time strengthening the organisation's need to relieve the body from its dysfunction: its inability to conceive is openly talked about at the FCE and within the field, but is still a taboo socially, outside of the field.

It is here that the consumeristic nature of the field emerges the most: due to the breaking of the taboo of infertility, the FCE is a locus where the decision to consume might take place. In this regard, the taboo is broken because the act of consumption is needed for the majority of the organisations at the Fertility Show to exist, but more importantly because, should the non-reproductive female body *not* consume any of the services and products within the field, its chances of becoming a maternal body would not increase. This would in turn fuel its assumed

emotional suffering, and perpetuate its taboo condition outside of the Show and the field.

7.4.2. Historical Links to the Cared for Body and the Parent/Child Relation: Maternalism and Family Building within British Society

The management of responsibility underpinning the construction of the cared for body and of the parent/child relation are linked to broader historical discourses on maternalism and family building.

The concepts of maternalism and family building were particularly being used in the first half of the twentieth century in relation to women's fertility. Created in the early 1900s with the aim of advancing women's economic and political interests (Cooperative Women's Guild, 2016), the Co-operative Women's Guild pushed for women's economic independence from their husbands: their role as mothers and wives was not contested, but rather unchallenged and taken for granted. A woman's place was in the home, despite the acknowledgement of her economic equality to her husband. The stress was on the woman's economic independence through work, yet her calling was still to provide her children with an environment of "feminine moral purity" and "physical and spiritual cleanliness" (Pfeffer, 1993: 86). This "cult of maternalism" (Pfeffer, 1993: 87) interested many levels of society, from the British government to the suffragettes (Black, 1984).

Particularly during the inter-war period, women were portrayed as wives and mothers whose life was primarily to take place within the private sphere. Such messages came from popular culture and the state alike; the British government "forced women to resign from public service jobs on marriage, assumed that wives were the dependents of their husbands and

refused to introduce equal pay for equal work" (Beaumont, 2000: 412). This widespread attitude was related to the post-war re-establishment of traditional gender roles that saw the "ethos of 'domesticity'" rise and persist until the 1990s (Bingham, 2004).

The suffragettes also benefitted from maternalism in elaborating their arguments, stressing, in what today would be considered close to a liberal feminist position, that women's economic freedom "was in men's interest because it would encourage the introduction of policies that would save the lives of their offspring" (Pfeffer, 1993: 87). A number of policies were, in fact, introduced (such as the 1907 Notification of Births Act aimed at examining the causes of infant mortality), but none of them were concerned with women's ability to procreate: this was still considered a private matter in the hands and authority of the husband.

The concept of family building had been at the centre of public discourse and attention since the 1930s: children had to be 'spaced' in order for the family to be manageable and to avoid disrupting the sexual relationship of the married couple (section 7.3.1.). The concept gathered strength also thanks to the rise of Taylorism coupled with "the language of post war reconstruction and the belief in the importance of planning" (Pfeffer, 1993: 19). Families and sexual and marital relationships were, then, to be built and maintained in a manner similar to how a factory would be managed. In a society increasingly focused on planned procreation, the main threat to the family was identified as unplanned pregnancies rather than sterility and infertility; reproduction was badly managed when children were being born without any careful and planned considerations.

A moment of shift in the approach to infertility and gynaecological dysfunctions was represented by the setting up of the New York-based Committee of Maternal Health (CMH) in 1923 by gynaecologist Robert Latou Dickinson, who

> "believed that a systematic, scientific approach to the management of gynaecological, marital, and sexual dysfunction and to problems of fertility… would solve many modern social evils consequent on uncontrolled parentage: poverty, overcrowding, delinquency, infant mortality, child labour and war." (Pfeffer, 1993: 53)

Dickinson's ideas were in line with those of the sex reformers in Britain, namely Stopes. The CMH work stressed the importance of empirical research in practice, which, as an approach, deeply changed the sex reformers' discourse and agenda around reproductive medicine. It is around this time that reproductive physiology, sexology, and scientific contraception were provided plenty of room in sex reformers' discourse (Pfeffer, 1993). The relevance of the CMH does not only lie in its empirical approach to reproduction: Dickinson's discourse stresses the importance of the *management* of 'gynaecological, marital and sexual dysfunctions'. Just like the work in a factory, a dysfunctional body that is not reproducing will need careful management.

These ideas further stemmed from a political environment that was heavily based on the idea of societal consensus against the threat of communism. The British welfare system, with its aim of reducing inequalities and homogenising British society, fuelled the concept of consensus. Gender roles within the family were firmly separated and "the exclusion of women from the workplace was interpreted to mean that they had willingly abandoned paid employment taken up during the war in order

to devote themselves to housewifely duties" (Pfeffer, 1993: 20; see also Bingham, 2004).

The 1960s were a decade of regulatory loosening around access to family planning and birth control technology, making women's reproductive lives highly focused on planning and avoiding having unplanned and/or badly spaced children. In the name of scientific progress, which distinguished the liberal and advanced West from the communist enemy, contraceptive methods based on advancements in pharmacology and medical technologies were key to the maintenance of a collective and planned management of British society (Wang, 1999; Bashford and Levine, 2010).

Infertility and infertility treatment in Britain, devoid of any regulation, came to the centre of public attention only in 1978 with the birth of the first test tube baby. From that moment, "a quarter of a million 'desperate', involuntary childless women appeared in Britain. Infertility seemed to be a new disease" (Pfeffer, 1993: 27). Medical articles appeared trying to find reasons for this sudden rise of infertility (see Page, 1988; Aral and Coates, 1983). Planned motherhood and maternalism were thus well established concepts by the time the Warnock Committee debated on how infertility was to be 'alleviated' by reproductive technologies (Warnock Committee, 1984).

7.4.3. Present Traces of Past Discourses: Maternalism and Family Building Within the Field

The cared for body calls for the management of reproduction through practices of care, and fosters an individual sense of responsibility towards treatment outcome. The social taboo of infertility is broken at the Fertility Show, which strengthens the importance of organisations therein. The responsibility for the possible outcome is constructed as shared:

I discussed how such construction highlights the consumeristic nature of the field of fertility treatment, in that the female body is partly responsible for the treatment process and outcome, and this responsibility depends on the choice the female body will make of which products and services to consume. Furthermore, at the FCE and in the field the female body is expected to break the social taboo of infertility with the organisations therein. This gives such organisations a privileged position within the female body's life, even outside of the field and the FCE. I highlighted the importance of the consumeristic nature of the field, in that if the female body does not consume products and/or services within the field, her chances to become a mother will not increase and her assumed suffering will not be relieved.

I then discussed how the concept of maternalism, the assumption that the female body will necessarily have to become maternal, was unchallenged throughout the development and social acceptance of birth control in the UK. Indeed, until 1978 reproductive medicine had focused on maintaining the family unit well organised through the efficient timing of a couple's offspring.

At the Fertility Show, the concept of maternalism is still unquestioned and is employed by organisations to foster shared responsibility for possible treatment outcomes: the female body will need to take charge over the care they will be receiving and giving to themselves in order to become a mother. This sense of responsibility is necessary precisely because of the unchallenged notion that maternity is always desired and socially expected of the female body.

The concept of family building is present at the Fertility Show, too. Whereas in the past the concept was used with

regards to birth control in order to efficiently manage and limit the family unit rather than challenging the concept of maternalism, at the FCE today family building (thus maternalism too) is maintained through the consumeristic nature of the field itself: in order to build a family, which is assumed as incomplete without children, an act of consumption is necessary.

While the absent challenges to maternalism might not be surprising in a field where the aim is to render the non-reproductive body reproductive, the concept of family building has shifted from viewing building a family as an act of control over births to seeing it as an act of encouraging the birth of children where naturally difficult. This encouragement within the field is, once again, not surprising: nonetheless, what is still present is the stress on the careful planning of children to be had.

This can be noted, for instance, with the governmental campaign One at a Time (HFEA, 2016h) which stresses the risks linked with multiple embryo transfers to the woman's womb. The risks are first and foremost medical, and relate to the possibility of multiple births. Nonetheless, the underlying message is still that 1) a childless life is not satisfying; and 2) that the woman, or couple, should only have one child at a time. One could argue that the concept of family building is not so stark in this last remark. However, the chances of a live birth through fertility treatment are notoriously low (HFEA, 2016g); the chances of a second successful treatment process, should the woman wish to have a second child, are not generally higher (Kalu et al., 2011).

7.5. Maintaining the Pragmatic, Moral, and Cognitive Legitimacy of the Field

In light of the emerging bodies and relations at the FCE, and of the reasons for their legitimacy therein, we can more specifically reflect on how each maintains pragmatic, moral, and cognitive legitimacy of the field.

7.5.1. Medical Body and Detached Authority/Object Relation

The relation that sees the organisation as a detached authority with regards to the object body maintains pragmatic, moral, and cognitive legitimacy of the field as follows:

1. *Pragmatic legitimacy* was maintained through time by the *late governmental intervention* within the field, which allowed a tangible detachment from the female body. The detachment is more evident with regards to the strong governmental focus on the potential future life from its earliest intervention in the field in the early 1980s. This in turn allowed for market-based organisations to flourish within the field. Legitimacy to intervene upon the object body is thus also maintained through competition within the marketplace: organisations employ competition as a tool to maintain authority over the object body by still constructing themselves as 'champions of fertility' able to render the female non-reproductive body reproductive (in contrast to, for instance, organisations suggesting adoption and fostering as parenting 'alternatives').
2. The body-object is *morally* legitimate because it carries traces of past discourses that saw the woman's body primarily as *a vessel* for future life, separated from experience and feelings. The historical view that the 'right thing to do' was to preserve fertility in order for women

to become mothers and thus happy is today still largely unquestioned.

3. *Cognitive* legitimacy is maintained through medicine's historical decisional power over what is medically and socially normal or deviant; and by the historical removal of agency from the female body, which is still present in the object-body.

7.5.2. Distressed Body and 'Equal' Empathiser/Suffering 'Peer' Relation

The distressed body and the relation it engenders maintain the field's pragmatic, moral, and cognitive legitimacy as follows:

1. These constructions find *pragmatic* legitimacy in the historical 'habit' of setting external priorities over the woman's reproductive life. I showed how even when the women's movement and Stopes began to publicly discuss reproduction and contraception, their interests were first and foremost political (feminists were primarily interested in enfranchisement and economic independence) and eugenicist (Stopes' main concerns were with the population's racial stock). Today, priority is given to the potential future life, mostly through the personification of it (see also section 5.5.3). This priority is necessary for organisations at the Fertility Show and in the field to legitimise and carry out their activities.
2. The constructed relation is *morally* legitimised by the organisations' assumption that an infertile body cannot possibly be happy: this in turn derives from the unquestioned 'sacredness' of motherhood.
3. The *cognitive* legitimacy of the distressed body is shaped by the personification of the future life: organisational

intervention is legitimate because only organisations within the field are able to turn the potential future life into a reality, thereby relieving the distressed body from its emotional suffering. Such legitimacy in turn reiterates the process of setting external priorities over the woman's reproductive life: if, earlier, the priorities were political and eugenicist, today they are strongly focused on the potential future life. I understand this type of legitimacy as *cognitive* because organisations talk about the potential future life as if it were already a born child, whose humanity is taken for granted and prioritised over the woman's.

7.5.3. Cared for Body and Parent/Child Relation

The cared for body and the parent/child relation contribute to maintaining fertility treatment's legitimacy in the following ways:

1. This construction maintains *pragmatic* legitimacy because of the great stress on the management of reproduction deriving from the concepts of maternalism and family building. The cared for body is legitimate thanks to the idea that management and care are needed throughout the female non-reproductive body's life. This body and relation require the prospective patient to buy goods and services that would best contribute to a successful management of their condition.
2. The parent/child relation is *morally* legitimate because by setting expectations on both themselves and the body, organisations are in fact managing the body's agency by telling prospective patients what *the right thing to do* is. This is done by telling the prospective patient not just how

to take care of themselves, but also what appropriate organisational care looks like.

3. *Cognitive* legitimacy is maintained through the legitimising belief that the mother-to-be attending the Show is also necessarily a consumer. Only by buying the right goods and services in the field can in fact the non-reproductive female body take appropriate care of herself, and hence increase her chances to become a mother and prove the field successful (consequential legitimacy).

Further, we can see how the legitimacy of the three discourses is interlinked: a) the medical body maintains the field's legitimacy because the female body is still understood as a vessel; b) the distressed body maintains legitimacy because a vessel body only exists to create a life other than its own, hence when such life is missing the body is assumed to be suffering; c) the cared for body is legitimate because the potential future life is prioritised over the (vessel) body in distress. Because of this priority, the body in distress will have to take active steps to manage their life and take responsibility for their acts of consumption within the field.

Table 19. Maintaining Pragmatic, Moral, and Cognitive Legitimacy.

Body and Relation / **Type of Legitimacy**	**Medical Body** **Detached authority/Object**	**Distressed Body** **'Equal' Empathiser/Suffering 'Peer'**	**Cared for Body** **Parent/Child**
Pragmatic	Late governmental intervention in the field; Organisations in the field as 'champions' of fertility.	Organisations in the field setting external priorities over the woman's reproductive life: from political and eugenicist interests, to the potential future life.	Importance of management of reproduction; Prospective patients need to buy the right products and services in order to successfully manage their condition.
Moral	Victorian ideal of women happy when married mothers; Social need to preserve fertility.	Unquestioned sacredness of motherhood.	Shared expectations of 'the right thing to do' to increase chances of live births; Shared responsibility of possible treatment outcomes.
Cognitive	Medicine's power over what is normal and deviant in reproductive medicine; Removal of agency from the female body.	Personification of the potential future life.	The mother-to-be is necessarily also a consumer.

7.6. Strategies to Maintain Legitimacy: Reiteration, Adaptation, and Interruption

Through the results presented in chapters 5, 6 and 7, we can see that the discursive strategies organisations at the Fertility Show employ to maintain legitimacy are the reiteration of past discourses; the adaptation to current social norms; and the interruption of external social norms at the FCE. Specifically:

- Within the discourse of the medical body, organisations *reiterate* the understanding of the female body as a vessel and the unquestioned happiness found in motherhood. Simultaneously, organisations at the FCE and in the field need to *adapt* to current social norms that no longer view marriage as a necessity for motherhood to take place, and that understand motherhood to be achievable also for same-sex couples, single women, and women over 40. This translates into organisations offering treatment, products and services to these categories of women, and thus constructing them as medical bodies.
- Within the discourse of the distressed body, organisations *reiterate* women's maternal role in society as wanted and needed. At the same time, organisations *adapt* to the current social environment by moving away from past discourses that overtly prioritise the 'quality' of the potential future life in relation to broader national or international political concerns; instead, organisations focus on the happiness the potential future life would bring to the distressed non-reproductive body.
- Within the discourse of the cared for body, organisations *reiterate* the female body's responsibility to become a

mother, as well as the necessary management of their life within and outside of the FCE and the field. However, organisations also *adapt* to the current social environment by constructing a shared idea of responsibility which in turn underpins the consumeristic nature of fertility treatment: treatment outcome is partly the female body's responsibility. This promotes a level of agency on the female body's side that was not welcomed in the past, but is now necessary both due to current social norms and due to the nature of consumerism within a capitalist society – where individual choices are constructed as paramount. The construction of the cared for body further brings out a third strategy employed by organisations to maintain legitimacy at the FCE, and that is *interruption*: at the Fertility Show, the taboo of infertility is temporarily interrupted, thereby providing organisations with an upper hand to discuss the field's issue (infertility) and construct themselves as socially needed by the female non-reproductive body. Outside of both the FCE and the field, however, the taboo remains intact.

Table 20. Legitimacy of the Field of Field of Fertility Treatment: A Summary

Context: Field Emergence and Development (chapter 3)	**Bodies and Relations at the FCE (chapters 5 and 6)**	**Explaining Legitimacy (chapter 7)**
Legitimacy needed with regards to: • Ethics of life[1] • Potential future life • Scientific advancements (eugenics)	<u>Medical body</u> *Legitimacy maintained through:* Tests, medical examinations, scientific procedures. *Organisations involved:* Medical and governmental. *Relation engendered:* Organisation as detached authority, body as object. <u>Distressed body</u> *Legitimacy maintained through:* Emotional fulfilment through the obtainment of a live birth. *Organisations involved:* Clinics, businesses, NGOs. *Relation engendered:* Organisation as 'equal' empathiser, body as suffering 'peer'.	*Legitimacy deriving from:* <u>Medical body</u> <u>Detached authority/object relation</u> • Body understood as vessel; • Late governmental intervention and focus on potential future life; • Competition as tool for legitimacy over the object body. <u>Distressed body</u> <u>'Equal empathiser/suffering 'peer' relation</u> • External priorities over the woman's reproductive life; • Assumed unhappiness of the non-reproductive body; • Personification of potential future life.

[1] In the late 1970s and 1980s social concerns over what was to be socially accepted in reproductive medicine largely centred on the power medicine had to create test-tube babies; whether this was an acceptable practice; and the potentially damaging consequences IVF could give rise to if such practices were to be available to many women (see chapter 3).

	<u>Cared for body</u> *Legitimacy maintained through:* Shift in responsibility; shared responsibility between organisations and the female non-reproductive body. *Organisations involved:* Private clinics, businesses. *Relation engendered:* Organisation as parent, body as child.	<u>Cared for body</u> <u>Parent/child relation</u> • Management of reproduction and individual responsibility for possible treatment outcome; • Setting expectations on both the organisation and the body; • Temporary breaking of the taboo of infertility.

7.7. Conclusion

This chapter has presented the social practice level of analysis carried out on the bodies and relations emerging from text analysis (chapter 5) and discourse practice (chapter 6). It has discussed how the discourse of the medical body and the detached authority/object relation is linked to pre-existing discourses on the female body and the role of medicine within reproduction (7.2.1), as well as to current constructions within the FCE informed by past discourses (7.2.2). With regards to the distressed body and the 'equal' empathiser and suffering 'peer' relation, the chapter discussed the historical priority given to external factors to the female body, such as political rights and eugenicist concerns (7.3.1), and how external priorities over the distressed body are still maintained through the personification of the potential future life (7.3.2). As per the cared for body and the parent/child relation, the chapter discussed the importance of the management of reproduction which in turn fosters a sense of shared responsibility towards treatment and sustains the social taboo of infertility outside of the FCE and the field (7.4.1). I discussed how the importance

of managing reproduction derives from the concepts of maternalism and family building, which gained prominence in the twentieth century in relation to post-war British society (7.4.2), and how the concepts legitimise the current importance given to the management of reproduction (7.4.3). In section 7.5 I presented how each body and relation maintain pragmatic, moral, and cognitive field legitimacy at the FCE. I then proceeded to argue how organisations at the FCE discursively maintain legitimacy through the strategies of reiteration, adaptation and interruption (7.6).

The next chapter presents the discussion of the research outcomes illustrated in chapters 5, 6 and 7; it shows how such outcomes address the theoretical gaps identified in chapter 2; and offers further reflections for our current understanding of the female (non-)reproductive body.

CHAPTER 8. DISCUSSION

8.1. Introduction

This chapter discusses the findings presented in chapters 5, 6 and 7, and illustrates how each chapter answers the research questions and addresses the aims of the thesis. Thus, it first recapitulates the research aims and questions (8.2) before proceeding with discussing how each has been answered through data analysis (from 8.3 to 8.7). I therefore discuss how organisations at the Fertility Show construct the body, which relations they construct, and how and why such constructions maintain field legitimacy. I then present the thesis' findings in relation to discursive strategies for legitimacy maintenance, before discussing FCEs as discursive spaces (8.8 and 8.9). I then discuss the thesis' contributions and relevance to organisation studies focused on the female body and on the female non-reproductive body in particular (8.10). I finally conclude the chapter (8.11) before proceeding with concluding the thesis in chapter 9.

8.2. Research Aims and Questions

This research was set up with the aims of broadening our knowledge of FCEs, discourse and legitimacy, and organisational constructions of the female body in relation to reproduction. Specifically, we can recap the research aims as follows:

a. Within organisation studies concerned with FCEs, I noted a lack of studies on how discourses are generated at FCEs. In order to address this gap, I followed Hardy and Maguire's (2010) suggestion to approach FCEs as discursive spaces.

b. Within studies concerned with discourse and legitimacy, there are few empirical studies concerned with how discourse can influence legitimacy, particularly with regards to FCEs and how legitimacy can be discursively maintained therein. I noted how Vaara et al.'s model for processes of discursive legitimation (2006), informed by CDA, does not consider social practice and does not include text consumers when analysing discourse. These were two important features I had to consider to address my research questions and aims. To understand how legitimacy is maintained at the FCE through discourses of the female body, my analysis explicitly focussed on the construction of text consumers at the Fertility Show, and contextualised such constructions to question the reasons underpinning the discourses and relations which emerged from analysis. This required me to move away from Vaara et al.'s model, and to adopt a model entailing a different approach to the analysis of discourse.
c. Further, the FCE presents a very peculiar landscape in that it is an event that is spatially and temporally bounded, and characterised by uncommon or novel interactions (Hardy and Maguire, 2010). In this regard, most studies on FCEs have focused on field configuration, while we still know little as to how field maintenance takes place at the FCE (Schüssler et al., 2014). This, in turn, brings up reflections on legitimacy.

I thus posed the following overarching question:
How do FCEs discursively maintain field legitimacy?

I chose to analyse the field of fertility treatment, where the FCE is represented by the Fertility Show. I particularly examined how organisations in this FCE employ discourses of the female

non-reproductive body to maintain field legitimacy. In order to answer this question, I was further guided by the following research questions. At the Fertility Show:

4. How do organisations discursively construct the female non-reproductive body?
5. What relations are discursively constructed between the organisations at the Show and the constructed bodies?
6. How are these bodies and relations maintaining field legitimacy?

The reasons underpinning the thesis' specific focus on fertility treatment are linked to a number of gaps identified in the literature regarding organisations, gender, and the body. Specifically:

a. within organisation studies focused on the body, I noted a lack of studies that position the body as the material centre of the analysis in relation to organisations;
b. within studies focusing on the female body and organisations, most attention is paid to the pregnant or maternal body, leaving the infertile or non-reproductive female body outside of academic conversations; and
c. analyses of organisations and bodies have been limited to a specific organisational setting, a specific profession, or a single organisation, leaving a gap concerning how organisations relate to the female body at the broader field level.

Focusing on these concerns allowed me to investigate:

1) how organisations in a FCE and thus belonging to the same field construct the same type of body, and how they particularly construct the body which is at the explicit centre of the field's activities;

2) how organisations further employ specific discourses of the female non-reproductive body to construct specific relations between themselves and the female non-reproductive body;

3) based on the bodies and relations constructed by organisations, the questions allowed to examine the strategies employed by organisations at the FCE to maintain pragmatic, moral, and cognitive legitimacy, both within the field and at the social level beyond organisational boundaries. Consequently, the analysis allowed me to further understand how discourses are generated and employed within the FCE setting.

The following sections discuss the findings for each research question; the implications for legitimacy, discourse and FCEs; and the study's contribution with regards to organisations involved with the female non-reproductive body.

8.3. How Organisations Construct the Female Non-Reproductive Body at the Fertility Show

Chapter 5 presented the discourses of the female non-reproductive body constructed by organisations at the FCE. The three discourses are that of the medical body, of the distressed body, and of the cared for body. The medical body entails an understanding of the female non-reproductive body as something to be examined, fragmented, and to be looked at in its animal features; it is a body that primarily exists under the medical gaze, understood in positivist terms and as essentially flawed, thus in passive need of medical intervention.

The discourse of the distressed body entails an understanding of the female non-reproductive body as a body that is in a default state of emotional suffering: it is a body that is in distress, socially dysfunctional due to its inability to reproduce, and only able to be successful through

organisational intervention. Such intervention can be on multiple fronts, all of which are present at the FCE: medical, governmental, civil society, and business organisations are all present to relieve the distressed body from its grief.

The third discourse is that of the cared for body, which understands the female non-reproductive body as one that needs to be taken care of while simultaneously having to take care of itself and gain some level of control over the process of treatment. Sometimes such control is to be gained through decision-making at the clinic, while other times it is gathered by accessing other organisations in the field, such as for instance approaching an NGO or a particular business selling products that are recommended to complement treatment and 'enhance the chances of success'. The female non-reproductive body is thus taken care of by the organisation, through practices aimed at teaching, treating, patronising, empathising, and/or supporting. The cared for body is importantly also expected to take care of itself through exercise, diet, information gathering, and stress relieving: success (and hence motherhood, and hence happiness) cannot be achieved without active and proactive participation from the female non-reproductive body's side. The organisation will provide care, but at the same time the body is reminded that success cannot be achieved through organisational intervention alone. This provides ground for the responsibility of the body with regards to organisations at the FCE and, more broadly, in the field: there is only so much that each organisation can do. Further, the discourse of the cared for body highlights ways in which the body can feel or be in control of part of the process. By keeping up to date with scientific and technological procedures and services, by maintaining a healthy lifestyle, or by undertaking

scheduled activities, the female non-reproductive body is told that some level of control is always possible.

8.3.1. Dualisms and Co-constructions

Within text analysis, three dualisms or co-constructions emerged. The medical body constructs a passive body that is simultaneously flawed in its biological essence; here, experience is removed from the body, and infertility is placed on a fragment of the body to be examined rather than on the social condition of the individual or their emotional and personal experience of non-reproduction or treatment. The co-construction of a positivist and flawed body allows organisations in the field to take distance from the body and to simultaneously exercise authority over it.

The distressed body entails the dualism of both emotional suffering and success, and creates a sense that a successful body is a fertile one, whereas an infertile body is in distress and unsuccessful. Thus a body that is not maternal is understood as always grieving and socially unsuccessful.

Lastly, the cared for body creates the dualism of passivity and agency. The body that is taken care of by organisations is constructed passively as a receiver of organisational intervention, but is nonetheless a body that simultaneously takes care of itself and therefore possesses a certain degree of agency. Within this dualism, agency is always somewhat managed by the organisation: it is the clinic, or the NGO, or the counsellor that will tell the female body how to take care of herself. Agency becomes 'activated' by the organisation, which is thus still requiring the prospective patient to passively comply.

On the female body's side, these dualisms imply a necessary degree of passivity that is reinforced by the positive

aspect of each dualism: her body parts can be selectively 'cured' because non-reproduction is constructed as a flaw; the insistence on success is needed because her non-reproductive body is constructed as emotionally suffering when infertile (thus unsuccessful); and her agency, which is definitely present, nonetheless needs to be carefully managed by the organisations at the FCE and in the field.

8.4. Relations Organisations Build with the Constructed Bodies at the FCE

Each of the discourses emerging from text analysis engender an imbalanced relation between the organisations and the prospective patient.

Through the discourse of the medical body, organisations at the Fertility Show position themselves as detached authorities with regards to the female non-reproductive body they will intervene upon. They separate themselves from the body by separating the organisations from their activities or interventions, as well as by employing neutrality when addressing the body (as in the use of the genderless patient presented in section 6.3.1). The detached authority/object relation allows organisations to examine, diagnose, and test; it further maintains the focus on the medical and scientific procedure rather than on the organisation carrying it out or the body being involved in such organisational practices.

The discourse of the distressed body engenders a relation that sees the organisation becoming an 'equal' empathiser with respect to the suffering 'peer' that is the female body. This relation engenders a sense of empathy and closeness on the organisational side, while simultaneously maintaining authority over the cause of distress and the ways to cure it. Organisations involved with the distressed body will relate to its experience

and ‘know what it feels like’, and reassure it that its dream will come true thanks to the organisation’s intervention. The use of this discourse attaches the concept of reproduction to the non-reproductive female body’s emotional fulfilment and social functioning. The body’s need for the organisation to intervene is only natural given the assumed state of distress that must derive from childlessness. This need is strengthened by the provision of organisational support throughout treatment, as shown for instance by the compulsory presence of counsellors at HFEA licensed clinics, as well as by the seminars given at the Show about the ‘emotional rollercoaster’ that is fertility treatment. This is not to say that there would not necessarily be emotional pain in those seeking treatment, but rather that a discourse presupposing such distress is employed by organisations to construct themselves as needed in relation to the prospective patient’s happiness.

The cared for body engenders a parent/child relation: like a parent, the organisation will teach and support the female non-reproductive body and will do so in their interest and for their own good. At the same time, as a growing child, the female non-reproductive body is expected to take active steps throughout the process of treatment - before, during and after. Diet, exercising, ‘doing homework’ by learning about existing regulations and the latest available treatments and technologies, and finding ways to successfully reduce stress are all practices that organisations expect from the body they will intervene upon. Such expectation has two purposes: 1) it relieves the organisation from some of the responsibility of the treatment’s outcome, and 2) it gives the body a sense of being in control of part of the process in an organisational field that is socially, ethically and emotionally already charged.

The parent/child relation partly shifts the responsibility of the treatment's possible outcome: should it be positive, then the parent successfully taught and led the child through the maze of knowledge, issues, and tests within the field, and the child successfully learnt how to take care of themselves by 'doing their homework'. Should the result be negative, then the responsibility for it will not be entirely on the parent, but also on the child who did not take care of themselves appropriately or sufficiently.

The three relations are imbalanced in favour of the organisations in the field. This imbalance emerged through the analysis of modality and presuppositions. Specifically:

- *Authority/object relation*. In this relation, objective modality and categorical modality are employed to construct organisations as authorities with regards to the prospective patient. Further, auxiliaries are used to prescribe organisations' behaviour onto the object body, and focus on the action to be performed rather than on the prospective patient. In this regard, detachment from the body is also achieved by de-gendering the patient. Organisations presuppose that prospective patients possess insufficient technical knowledge to fully understand fertility issues, and exploit this presupposition to construct themselves as needed to fill this information gap. They are the best suited to do so because they are the authorities in this regard – they established themselves as such through categorical modality.
- *'Equal' empathiser/suffering 'peer' relation*. Here subjective modality is employed to establish closeness between the organisation and the prospective patient,

while the use of objective modality simultaneously maintains the organisation's authority over the patient's emotional wellbeing. This relation entails the presupposition that infertility is an urgent and serious matter that needs organisational intervention, and that the prospective patient is in a default state of emotional pain that only organisations can relieve.

- *Parent/child relation*. This relation entails the use of subjective modality to construct a familiar sense of care between the organisation and the prospective patient, where the organisation undertakes a parenting role toward the body (child). Organisations presuppose that treatment is stressful and technical scientific knowledge is intimidating to prospective patients. As infertility treatment is constructed as a daunting process, even when patients obtain some level of control, organisational care will still be needed.

8.4.1. Creating the Need for Organisational Intervention onto the Female Body

The relations constructed between organisations and the prospective patients highlight how organisations at the FCE will not just construct themselves or other specific organisations as needed; they will construct *all the organisations in the field* as needed. For instance, from a private clinic's perspective, the female body will not only need medical care, but emotional support and lifestyle management too. Organisations understand that *all* organisations at the FCE benefit from constructing the whole field as necessary throughout the female body's life. This may seem to clash with the competitive nature of the marketplace described in chapter 3 and later emerged in chapter 6: after all, organisations do construct themselves as

better suited than their competitors to take care of the female body. However, this is only done with regards to organisations that offer similar products or services. The same dynamic does not take place among different types of organisations; thus, for instance, a private clinic would not construct itself as a better suited organisation to deal with the emotional suffering of the female body than a counsellor, but would instead construct the female body as in need of both medical intervention and counselling.

This too maintains organisations at the FCE in a privileged position with respect to the female non-reproductive body: even if organisations need the female non-reproductive body as a recipient of products and services, discourses employed by organisations at the FCE stress that it is the female non-reproductive body which is in strong need for organisational intervention. Such intervention is, in turn, collective rather than based on single organisations. This recalls the acknowledgment of FCEs as loci for organisations to solidify collective understandings and aims (Lampel and Meyer, 2008; Wooten and Hoffman, 2016), and suggests that organisations at the FCE discursively 'work together' to maintain the field and the activities therein legitimate.

8.5. Historical Links to Bodies and Relations

In chapter 7, I examined how the bodies and relations constructed by organisations at the FCE are linked to historical discourses that existed prior the emergence of fertility treatment in the UK. I showed how the discourse of the medical body separates the body from the experience and context of infertility, and understands the female body as a vessel. Historically, this understanding derives from: a) medicine's power to define what is normal and what is deviant with regards

to the female reproductive body; and b) from medicine's social influence particularly on the concept of motherhood as naturally desired by all women, and as the only fact of life that would truly make them happy. Further, the late governmental intervention in the field legitimised organisational detachment thanks to the field's strong focus on the potential future life; at the same time, it raised the authority status of the organisations that had been existing and working in the field before the birth of the first IVF baby in 1978, and that contributed to the development of the field within the private sector. Thus, like in the nineteenth and twentieth centuries, the medical body further constructs organisations as champions of fertility at the Fertility Show and within the marketplace more broadly.

The distressed body is instead historically linked to political and eugenicist priorities set over the female reproductive body throughout the historical and medical development of reproductive medicine and birth control. The discourse of the distressed body is sustained by the medical body, too: concepts of unquestioned motherhood and of the female body as vessel derive from medicine's historical power over linking social norms with medical ones, particularly with regards to reproduction (Laqueur, 1987; Longhurts, 2001; Pfeffer, 1987; 1993).

I discussed how the social norm that viewed women as potential mothers went largely unchallenged by the women's movement until 1960, and how the initial aim of birth control technologies was not to prevent the birth of children, but rather to time them effectively. Linked to this focus on controlling rather than limiting births is the historical discourse that understood birth control as a political tool to manage the British

population, rather than to advance women's reproductive choice. I showed how the social call for motherhood is still present at the FCE. This might not be surprising given the aim and nature of fertility treatment, but I noted how at the event there are no suggestions that infertility is something that can be happily lived with. This strengthens the relation that sees organisations as *'equal'* empathisers: they understand what infertility feels like for prospective patients, but at the same time they are the authorities that know how to relieve the emotional pain of childlessness.

Further, the distressed body prioritises the future life over the woman's, and personifies it: by portraying the potential future life as already human, at the FCE the field is kept legitimate by virtue of its ability to make such humanised potential a reality, thereby relieving the body from its taken-for-granted suffering. By doing this, the future life replaces the historical priorities linked to politics and eugenics, and becomes the new priority that is positioned before the prospective patient's body.

The construction of the cared for body highlights the need for managing all aspects of the female body's life. Such need partly derives from a construction of the distressed body that places emotional suffering on a social condition (not being a mother) rather than on a medical one (being physically unable to have children). Historically, the discourse of the cared for body links to the concepts of maternalism and family building. The relation parent/child finds legitimacy through the expectations organisations set on themselves and the body: through them, organisations manage and 'activate' the female body's agency by informing them on when, why and how to employ their agency.

The management of reproduction in turn sustains the taboo of infertility outside of the FCE and the field. At the Fertility Show, the taboo is temporarily broken. The breaking of the taboo is possible because organisations at the Fertility Show know about infertility and are the ones to which the female body is expected to 'open up'. This dynamic legitimises the parent/child relation: like a parent to whom the child is expected to tell everything, organisations expect the female body to share their experiences, feelings, doubts, and troubles with the organisations in the field. Just like a child being protected by their parents, at the FCE organisations assure the female body that, within the field, it is safe from society's judgment over their taboo condition.

The legitimacy of each body and relation is shown to carry historical discourses that existed prior to the emergence of the field. At the same time, organisations at the Fertility Show employ these discourses to maintain pragmatic, moral, and cognitive legitimacy through the strategies of adaptation, reiteration, and interruption. This is discussed in the next sections: I first review how legitimacy was obtained during field emergence, before proceeding to discuss how the obtained legitimacy is maintained at the Fertility Show.

8.6. Obtaining and Maintaining Legitimacy: from Field Emergence to the FCE

Before discussing how each discourse at the FCE maintains field legitimacy, it is useful to review how legitimacy was obtained during field emergence. There are three strategies organisations can use to *gain legitimacy*: a) adapting to the requirements of current audiences; b) choosing among different environments the one whose audience will more likely support its practices; and c) manipulating their environment and

creating bases of support in relation to the organisations' needs (Suchman, 1995).

In chapter 3 I showed how organisations *adapted* to the emerging social concerns which related to the ethics of life and of the human embryo in particular through the creation of the Warnock Committee and, later, of the HFEA. As fertility treatment emerged, organisations further adapted to the new social requirements of finding a cure to infertility, while simultaneously addressing the social norm that expects women to become mothers. Years later, with the creation of a FCE, organisations in the field also *chose an environment* that provides the field with a supporting audience: the Fertility Show explicitly targets a "niche audience" who is "looking for answers and treatments to help them on their fertility journey" (Fertility Show, 2016). Thirdly, the field obtained legitimacy by creating bases of support centred around their particular needs. This was achieved thanks to the creation of a diversified pool of organisations dedicated to supporting individuals pre-, during and post-treatment (as in the case of counsellors, NGOs, and support groups).

The gained legitimacy was pragmatic, moral, and cognitive. To recap, *pragmatic legitimacy* addresses "the self-interested calculations of an organization's most immediate audiences" (1995: 579), whereas *moral legitimacy* has to do with 'doing what is right' and is based on normative evaluations of the organisation's activities. Moral legitimacy can be based on comprehensibility or taken-for-grantedness. *Cognitive legitimacy* is instead based on the understanding of the organisation as inevitable or necessary based on unquestioned and taken-for-granted social norms, and can be *consequential* or *procedural* (see section 2.2).

Amongst the organisations within fertility treatment, private clinics obtained *pragmatic legitimacy* through the adoption of ethics protocols and assessments, primarily to protect the profession in response to the many public concerns coming from the government, the public, patients, and feminist and religious groups. NGOs and professional associations gained pragmatic legitimacy by providing non-medical support to people undergoing or interested in treatment, and by providing prospective patients with technical information about treatment and counselling. *Moral legitimacy* was instead obtained by 'absorbing' the social norm that saw women as 'desperate' to become mothers, and that viewed infertility as something neither specialists nor patients ought to talk about (Johnson and Elder, 2015; section 3.3). As the field developed, in line with social developments, *moral legitimacy* was obtained by offering services and products to those women whose motherhood previously was not socially accepted – women in same-sex partnerships, single women, and women over 40. *Cognitive legitimacy* was instead gained thanks to the unquestioned cultural account of the primary importance of the ethical and legal status of the embryo. This was most evident from the mid 1980s to the early 1990s, when public discussions and regulations increased and culminated with the creation of the HFEA. Finally, as I presented the research context and the process of field emergence and the obtainment of legitimacy, I also noted how the female body was *already absent* from social and organisational discussions on fertility treatment.

Table 21. Gaining Legitimacy during Field Emergence: Strategies within the Field of Fertility Treatment

Strategy	Type of Legitimacy obtained (Chapter 3)
Conform to environments	*Pragmatic*: adapting to scientific developments in reproductive medicine; adopting ethics protocols; creating diversity within the field (NGOs, counsellors, other fertility-related businesses). *Moral*: offering products and services to unmarried couples, same-sex couples, single women, and women over 40.
Select among environments	*Pragmatic*: market-based decisions (legitimacy obtained through competition); creation of the Fertility Show.
Create new audiences and new legitimising beliefs; creating bases of support.	*Cognitive*: public emergence of infertile women as an audience in need of organisational intervention; unquestioned ethical priority of the embryo.

Adapted from Suchman (1995), see also chapter 3.

In chapters 5, 6 and 7 I presented the discourses of the body organisations construct at the FCE, the relations each discourse engenders, and the historical traces that it carries. I then presented how each body and relation *maintains* pragmatic, moral, and cognitive legitimacy.

The discourse of the *medical body and the detached authority/object relation* maintain *pragmatic* legitimacy through the competitive nature of the field: the majority of the organisations in the field are in fact businesses. I discussed how the increase of profit-driven organisations in fertility treatment was possible thanks to the late governmental intervention to regulate the field. Further, the construction of the medical body

maintains pragmatic legitimacy by reiterating the historical discourse of reproductive medicine's professionals as 'champions of fertility' that are thus legitimised to operate onto the object body. *Moral* legitimacy is instead maintained because the medical body is linked to past discourses that view the female body as a vessel for future life, and that placed women's happiness in motherhood. Further, moral legitimacy is maintained through the unchallenged social need to preserve female fertility. Finally, the medical body maintains *cognitive* legitimacy through two taken-for-granted cultural accounts: the historical notion that medicine decides what is to be considered normal and deviant when it comes to female reproduction, and the historical removal of agency from the female body when it comes to reproduction.

The discourse of the *distressed body and the 'equal' empathiser/suffering 'peer' relation* maintain *pragmatic legitimacy* because they sustain the need for peripheral organisations both at the FCE and in the field. This need is possible because organisational interventions onto the female body are made necessary in order to relieve it form its emotional pain. Importantly, these interventions are not limited to the medical domain: because the emotional suffering is encompassing, so it is the need for a variety of organisation's interventions. Pragmatic legitimacy carries traces of the historical 'habit' of setting external expectations onto the female body: if earlier such priorities were political, today they are represented by the potential future life. Because reaching a live birth is constructed as paramount for women, the presence of all organisations in the field is necessary to make the potential future life a reality and maintain organisations in the field needed and active. *Moral legitimacy* is instead maintained

because intervening on the female body to render it fertile is understood as not only right, but 'natural' given the historical traces of discourses that portrayed motherhood as sacred. This is in turn due to the taken-for-granted cultural account that sustains *cognitive legitimacy*: that is, happiness derives from motherhood, success is equalled with reproduction and infertility to failure. This duality is sustained by the personification of the future life.

The *discourse of the cared for body and the parent/child relation* maintain *pragmatic legitimacy* by sustaining the need for all organisations in the field and at the FCE due to the constructed necessity of managing reproduction. Different organisations acknowledge that the intervention of a single type of organisation will not suffice to 'cure' the female non-reproductive body. This renders all organisations at the FCE and in the field needed and pushes organisations to actively encourage the prospective patient to seek organisational help from a number of different organisations. In a similar way to the discourse of the distressed body, the cared for body maintains *moral legitimacy* by creating an encompassing need to intervene on the female body that moves beyond the medical domain. The female body will have to be taken care of and take care of itself medically, emotionally, physically, both privately and publicly. This is understood as 'the right thing to do' because only through careful self-control and self-management can the female body increase her chances to successfully reproduce. Shared expectations and responsibilities over what should be done to have a baby are set by organisations on both themselves and the prospective patient. *Cognitive legitimacy* is maintained through the taken-for-granted cultural account of the mother-to-be consumer, which sees the female body in a

constant state of potential motherhood that can be only achieved through an act of consumption within the field.

In the next section I present the strategies of adaptation, reiteration and interruption that organisations at the Fertility Show employ to maintain legitimacy.

8.7. Discursive Strategies Employed at the FCE to Maintain Legitimacy: Adaptation, Reiteration, and Interruption

The analysis shows how, in their quest to maintain legitimacy, organisations at the FCE partly adapt to current social norms; they reproduce discourses and relations rather than setting them anew; and they temporarily interrupt social norms. In the case of fertility treatment, the absence of brand new discourses is due to the unchallenged focus a) on the status of motherhood rather than on the physical body onto which motherhood is inscribed; b) on the potential future life rather than on the woman's life; and c) on the need to manage an assumed reproduction, rather than on discourses that suggest that a childless life can be lived by a body that is not emotionally suffering.

The data showed how organisations at the Fertility Show *adapt* to current social norms by rendering their products and services available to a wider audience that would have not been included in the past decades, such as single women, same-sex couples, and women over 40. Adaptation allows organisations at the FCE to sustain legitimacy in line with changing social norms. However, the analysis shows that the slower to change the social norm, the more *reiteration* will be needed to sustain legitimacy. This was particularly evident within the constructions of the medical and distressed bodies (chapter 5): despite the changing importance given to marriage and

heterosexual partnerships, organisations at the Fertility Show still reiterate society's reduction of women's social role to biological expectations of reproduction. In this case, such reiteration is due to long held conceptions of womanhood and motherhood that are hard to disrupt through discourses at the FCE alone.

Interruption is another strategy employed by organisations at the Show to maintain legitimacy. Organisations at the Fertility Show do so by temporarily breaking the social taboo of infertility. The interruption happens through both the parent/child relation and through the encouragement to buy and consume fertility-related products and services within the field (but not at the FCE). As such, I argue that organisations at the FCE also employ the strategy of interruption to maintain legitimacy. Interruption takes place through both the creation of a new audience (the mother-to-be consumer), and of the subsequent legitimising belief that in order to become a mother, the female body needs to be a consumer.

The mother-to-be consumer emerges throughout the data, and is an audience whose creation is possible only via the temporary interruption of the taboo of infertility at the Fertility Show. I have discussed how the vast majority of the organisations attending the event are profit-oriented (sections 3.6 and 4.8.1), how a pricelist page is often included in the documents collected, and how offers and refunds are available to prospective patients. The consumeristic nature of the field further emerged in chapter 6, where I demonstrated how organisations create relations while positioning themselves as better suited to cater to the non-reproductive female body's needs than their competitors in the market. At the same time, outside of the FCE the female non-reproductive body exists in

a society that still sees infertility as taboo, and hence that would not openly address its social need to reproduce. As a third strategy to maintain field legitimacy, interruption at the FCE level sustains the social need for the field's existence by focusing on a taboo that falls onto the field's target audience and final consumer (the female non-reproductive body) rather than being associated with the field's main concern and aim (the potential future life).

I here discussed how organisations at the FCE employ discourse to maintain field legitimacy. This is done by 1) the creation of specific discourses; 2) building relations; and 3) by grounding such bodies and relations on past discourses born prior to field emergence. Further, I showed how each discourse and relation maintains pragmatic, moral, and cognitive field legitimacy. I then argued that at the FCE legitimacy is discursively maintained through the strategies of adaptation, reiteration, and interruption. In the next section I discuss how these findings contribute to our knowledge of FCEs as discursive spaces.

8.8. FCEs as Open Discursive Spaces: Imbalanced Relations, Past Discourses, and Openness

With regards to FCEs, discourse, and legitimacy, there a number of implications to the research findings I have presented.

First, whereas FCEs are temporally, spatially, and conceptually bounded, discourses employed therein aren't. Discourses are malleable, they adapt, are reiterated from the past, and interrupted, but are not bounded or limited to the FCE context. When we approach FCEs as discursive spaces, the CDA approach I adopted to study FCEs shows that 1) through

discourse organisations create discursive spaces that are open to past discourses; and that 2) they generate *imbalanced relations* between themselves and text consumers that are underpinned by such past discourses. These underpinning past discourses, in turn, make such imbalanced relations harder to notice and indeed challenge. This might be due to the peculiar characteristics of FCEs: because they are temporally and spatially bounded, it is harder for text consumers to challenge the discourses employed therein. Resistance becomes more unlikely if we consider that such discourses partly derive from past discourses not explicitly available at the FCE.

This specifically addresses the gap noted by Hardy and Maguire (2010) with regards to how FCEs as discursive spaces delay or prevent change. My analysis shows that FCEs can prevent change by employing past discourses and integrating them with those employed at the event. With respect to the female non-reproductive body, at the Fertility Show field change is prevented when: a) women are still understood as passive vessels rather than agentic individuals in relation to their own reproduction; b) the absence of children is strictly tied to unhappiness; and c) the absence of reproduction is maintained as a social taboo that needs to be 'removed' from the female body in order for it to be happy.

Thus, organisations' use of discourse at FCEs make struggles over legitimacy involving text consumers difficult to manifest. Because legitimacy is bound to past discourses that are not directly available at the FCE, it is difficult for text consumer to identify them and challenge them.

In fact, discourses employed at the FCE are neither temporally nor spatially limited: rather, they *seep in* and *seep*

out, both in space and time. In space, because discourses and relations emerging from the organisational texts are linked to broader discourses on womanhood and motherhood that are present throughout our society. And in time, because the same discourses and relations are historically linked to past discourses on the same issues. We might view this fluidity of discourse as offering potential for resistance and change: resisting discourses might seep in, for instance, through peripheral or central organisations, perhaps in response to social changes or legitimacy threats. However, the temporal boundaries of FCEs make resistance to certain discourses arguably unlikely. I further discuss this with regards to future research in chapter 9.

FCEs can thus be seen as discursive spaces that are *open*. In this study, the discourses of the body are constructed by organisations as medical, distressed, and in need of care, and in specific relations to the organisations at the FCE. However, these bodies and relations importantly also derive from past discourses belonging outside the FCE and the organisational field. This implies that the discursive spaces created at the FCE are not fully generated ex novo; rather, they carry traces of past discourses that are not explicitly employed by organisations at the FCE. For instance, organisations at the Show do not explicitly address the female body as a medical object or as a vessel devoid of agency; rather, they build on such past discourses, isolate medical conditions and detach themselves from the prospective patient (as in the discourse of the medical body). It is thus important to acknowledge what traces of past discourses organisations in a field decide to take on when creating 'their own' discourses at the FCE.

8.9. Discursive Strategies at the FCE: Generating 'New' Discursive Spaces?

As I noted in section 2.2, due to the uncommon interactions taking place at FCEs, the discursive spaces opened therein are usually not available in the field (Hardy and Maguire, 2010). The analysis I carried out of the Fertility Show urges me to challenge this notion and suggest that more complex dynamics might be at play. The discourses that take place at the FCE are always at least partly already present in the field and in society; however, organisations in the field partly shape the discourses they create at the FCE on past discourses. It is thus not simply a matter of adapting to existing discourses, or of absorbing external discourses. In order to maintain legitimacy, organisations at the Fertility Show did not simply adapt to the notion of woman-as-vessel, nor did they just fully absorb the discourse that a woman's happiness lies in motherhood. The case of fertility treatment shows us that past discourses were *partly absorbed (or reiterated)* (woman as vessel); that discourses created at the FCE were *partly adapted to current social norms* (as in the inclusion of single mothers and same-sex couples); others were *partly created ex-novo* (mother-to-be consumer); and others *interrupted social norms external to the field* (as with the discourse of the cared for body and the taboo of infertility).

There are two considerations I wish to make with regards to how these strategies take place. The first one refers to the relation between the strategies of adaptation and reiteration. Adaptation can hide reiteration, and thus make it more difficult to challenge past discourses. Let us take the example of the discourse of the medical body. Here, traces of past discourses suggest that women are still seen as vessels. However, in line with social changes on gender and sexuality, organisations in

the field moved away from exclusively treating the married heterosexual woman, and instead offer treatment to a broader pool of diverse women (lesbian women, single women, 'older' women). Organisations' alignment with changes in reproductive rights and choice hides the less socially accepted reiteration of past discourses which, in this case, can arguably be considered sexist. By hiding this reiteration, adaptation presents organisations within fertility treatment as champions of reproductive choice rather than detached authorities, and fuels the consumeristic nature of the field by linking legitimacy to more types of female bodies to intervene on (thus to offer services and products to).

The second consideration refers to the strategy of interruption, which encompasses the three discourses of the female body. We can see interruption as maintaining legitimacy by strengthening the *us* (organisations at the FCE, but also within the field) *versus them* (society) dynamic. Organisations at the Fertility Show assure the prospective patient that not only is the FCE a safe space to talk about infertility, but that the whole organisational field is safe to open up to. On the other hand, outside of the FCE and the field, society might not be as safe. By doing this, they create a 'bubble', a temporary reality where discussing infertility is accepted, but infertility per se isn't. The taboo of infertility is only interrupted, not eliminated or challenged: rather, it sustains the need for organisational intervention and of the field of fertility treatment altogether. This is possible precisely because prospective patients can talk about the taboo of infertility to the only organisations that are able to intervene and eliminate their fertility issues through services and products (and thus remove the taboo).

The presence of the taboo was most evident in documents produced by counselling NGOs and professional associations, which assured prospective patients that they know and understand how discussing infertility may be hard even with family and friends (see section 5.6.1). Due to the socially sensitive nature of the field of fertility treatment, interruption might be a particularly fruitful strategy to employ when dealing with ethically sensitive or socially questioned issues. Should infertility not be considered a social taboo, its interruption at the FCE would not only be unnecessary, but it would also be of no use to gain or maintain field legitimacy. There would be no taboo to break, and no argument against which to make organisations legitimately needed to the female body. Temporarily interrupting social norms at the FCE thus fuels legitimacy: when organisations interrupt the taboo of infertility at the FCE, they reinforce the social acceptance of fertility treatment. When the taboo is broken, prospective patients feel safe not only to talk to organisations about their fertility issues, but they also trust the field enough to decide to become (possibly recurring) costumers.

These reflections on how the strategies for legitimacy maintenance work and interact bring me to argue that FCEs might not necessarily always provide opportunities for new discursive spaces to be created. The case of the Fertility Show shows that the employment of discourse may not be as much about creating new discursive spaces, but rather more a matter of shaping discourses in a way that reinforces legitimacy outside of the bubble that is the FCE as a discursive space. In sum, FCEs can be discursively created as separate spaces from society that fuel field legitimacy by virtue of being different from the 'outside world'. This can provide a valuable starting point for future

analyses of fields that deal with ethically sensitive or taboo issues.

8.10. Organisations and Female Bodies: Production Versus Reproduction

The study also addresses the gap within organisation studies and the body relating to how the female body is constructed when not fertile or reproductive. The findings show how not being a mother is tied to broader social and historical discourses that co-exist with discourses employed by organisations toward pregnant and maternal bodies. Unfortunately, feminists' critical arguments that women are seen as "maternal spaces to be filled" (Bacchi and Beasely, 2002: 335) are evidently still applicable. Further, I have noted how the tendency of personifying the potential future life, and to de-personify the female body's are just as present today as they were during field emergence (5.5.3). Indeed, the female non-reproductive body is but a means to a highly desired and prioritised end. Thus organisations that seem to vouch for reproductive choice (IVF, egg freezing, and so on) are in fact discursively contributing to social discourses and relations that maintain women's bodies objectified as vessels for new life. Such approach was present in various seminars I attended, where doctors would ascribe human characteristics to embryos (section 5.5.3). The female non-reproductive body is once again absent and deprioritised in favour of the organisation's main concern, which is at once their product and their reason for existence within the field.

With regards to organisation scholars concerned with the female reproductive body, in chapter 2 I discussed Gatrell's (2013) argument that maternal bodies simultaneously have to follow social expectations on motherhood and professional

expectations in the workplace. Indeed, the author presents us with a duality of expectations the fertile female body will face: social expectations (adhering to social norms around proper maternal health) and organisational expectations (maintaining professionalism at work) (see also Lyness et al., 1999).

The analysis shows how the expectations placed on the non-reproductive body are not that different from those placed on the fertile body. Indeed, by zooming out to include non-reproductive bodies, we can see that on the basis of its reproductive potential, social and organisational expectations inevitably burden the female body.

As a potential mother, the female body will have to respond to both social and organisational expectations regardless if a birth has taken place. I thus expand Gatrell's argument by showing that the duality of social versus organisational expectations, when including both fertile and infertile bodies, presents us with a lose-lose situation: should the female body be fertile and reproduce (thus fulfil social expectations of motherhood), its productivity will likely be questioned (organisational expectations questioned) (see section 2.5). Should the female body be non-reproductive, its productivity will likely not be questioned (organisational expectations fulfilled), but its role within society will be (social expectations questioned).

This lose-lose situation fuels problematic ambiguities with regards to fertility treatment and women's reproductive choice. It presents us with a conflict the female body experiences in relation to reproduction, regardless if the status of motherhood is achieved. This stands as a problematic dualism of expectations we need to consider when promoting the advancement of an agenda for women's reproductive choice

and rights. I reflect on how we as scholars can move on from this duality in section 9.4.

Table 22. Expectations on the Maternal Body and Expectations on the Non-Reproductive Female Body

Body / **Expectations**	**Maternal Body**	**Non-Reproductive Body**
Organisational (production, female body at work)	Questioned	Fulfilled
Social (reproduction, female body in society)	Fulfilled	Questioned

8.11. Conclusion

In this chapter I have discussed the research outcomes and provided post-analysis reflections on organisations and the female body. After reviewing the research aims and questions (8.2), I proceeded to demonstrate how each research question has been answered through text analysis (8.3), discourse practice (8.4), and social practice (8.5). In section 8.6 I discussed how organisations obtain and maintain legitimacy within the field. I argued how legitimacy to intervene upon the female body is maintained through the discursive strategies of adaptation, reiteration, and interruption (8.7). In section 8.8 I discussed how, in light of the emerging strategies, FCEs can be seen as open discursive spaces where past discourses seep in to underpin the discourses employed by organisations at the FCE. Because past discourses are not explicitly present at the event, they are harder to challenge and thus fuel organisational legitimacy. I argued that the use of past discourses, coupled with FCE's temporal and spatial boundaries, make changes difficult to achieve and resistance hard to carry out. In section

8.9 I discussed how, by virtue of how the discursive strategies I identified work and interact, FCEs might not necessarily provide opportunities for the creation of new discursive spaces. The analysis I provided showed that FCEs can be discursively created as separated spaces from society, and that the creation of this 'bubble' might in turn fuel field legitimacy.

Moving to my contribution to organisation studies and the female body, I then showed how the construction of non-reproductive bodies illuminates a lose-lose situation within the dualistic expectations of society and organisations and the female fertile and infertile body (8.10).

The next chapter concludes the thesis.

CHAPTER 9. CONCLUSION

This chapter concludes the thesis by providing a research summary (9.1), describing the contributions of the thesis (9.2), outlining some of the main limitations of the research (9.3), and making suggestions for future research (9.4). Finally, it presents some personal reflections and concluding remarks (9.5).

9.1. Thesis Summary

This thesis addressed how Field-Configuring Events discursively maintain field legitimacy, and particularly analysed the field of fertility treatment and the Fertility Show as one of its FCEs. It further focused on the discourses of the female non-reproductive body organisations at the FCE employ to maintain field legitimacy. The study examined how organisations at the Fertility show discursively construct the female non-reproductive body (research question 1), what relations they discursively construct between themselves and the bodies they construct (research question 2), and the reasons why and the strategies through which the bodies and relations constructed at the FCE maintain the field's legitimacy (research question 3). These questions were explored through document analysis and observation of organisational texts and seminars that took place in 2013 and 2014 at a field's FCE, the Fertility Show. The thesis suggests that organisations at the event employ three discourses of the female non-reproductive body: the discourse of the medical body, of the distressed body, and of the cared for body. Each discourse engenders an imbalanced relation between the organisations and the female non-reproductive body, and is linked to discourses on the female body that have been historically employed by organisations before the emergence of the field of fertility treatment. The three

discourses identified at the FCE maintain field legitimacy through three strategies: by adapting to current social norms, by reiterating historical discourses on the female body, and by temporarily interrupting social norms.

The study showed how FCEs can be approached as open discursive spaces: whereas FCEs are spatially and temporally limited, the discourses employed therein aren't. I noted how past discourses employed at the FCE maintain field legitimacy by making resistance difficult to carry out at the FCE level. I also argued that the strategy of adaptation can hide reiterated discourses at the FCE, and that interruption creates a separate discursive space that fuels field legitimacy by virtue of constructing the FCE as a safe bubble, separate from an unsafe society outside of the FCE and the field.

The analysis further brought me to argue that the female body, due to its reproductive potential, is locked in a lose-lose situation of social and organisational expectations which are impossible to simultaneously fulfil.

A review of the literature (chapter 2) presented the key concepts of legitimacy, organisational field, FCE, and discourse. It further introduced feminist literature on the female body and reproduction, and on organisation studies that focus on the body and on the female reproductive body in particular. Specifically, the review distinguishes three types of legitimacy (pragmatic, moral, and cognitive) and differentiates between gaining and maintaining legitimacy. Given the thesis focus on FCEs, I stressed how the focus of the study is on how field legitimacy can be maintained through discourse at the FCE. The chapter shows that scholars have stressed a lack of knowledge as to how discourses are generated and employed at FCEs, and on how we can understand FCEs as discursive spaces (Hardy

and Maguire, 2010), and as loci where field maintenance, which is tied to issues of legitimacy, takes place (Schüssler et al., 2014). Further, literature on discourse and legitimacy has so far seen one model developed for processes of discursive legitimation (Vaara et al., 2006). However, the model does not consider text consumers in its analytical process, nor does it analyse social practice with regards to discourses employed by organisations. Both were important starting points in my analysis. Further, Vaara et al. focus on processes of legitimation, whereas my analysis centred on how FCEs discursively maintain field legitimacy.

The chapter further highlighted how, in organisation studies focused on the body, we do not have studies that focus on how conceptualisations or constructions of the body can be employed towards legitimacy; how the body has mostly been analysed when at work or undertaking an organisational role; and how little attention has been paid to the body in the organisational settings of the organisational field and the FCE in particular. The review concludes by showing how, within organisation studies and the female reproductive body, scholars have prioritised the fertile or maternal body. By doing so, silence on the female infertile or non-reproductive body is maintained.

Chapter 3 presented the research context, and showed how the emergence and development of fertility treatment was due to public concerns with regards to the ethical and legal status of the embryo rather than women's reproductive lives or bodies. Concerns over the female non-reproductive body were advanced primarily in relation to the potential future life that could have resulted in a live birth thanks to organisations operating within the field of fertility treatment. The chapter

further highlighted how, by the time the field had emerged and developed, the female body was already 'presently absent' due to the societal focus on the ethics of the embryo. I concluded the chapter by highlighting how pragmatic, moral, and cognitive legitimacy was obtained during field emergence.

Chapter 4 presented the research philosophy and methods, and particularly discussed the social constructionist approach to research; the importance of discourse and the employment of Fairclough's CDA; the research design, the process of data selection, and the analytical framework adopted; research validity and reliability; and the limitations of adopting CDA to analyse data.

The three empirical chapters respectively addressed each research question. Chapter 5 addressed research question 1 and focused on text analysis. It showed how organisations at the Fertility Show employ three discourses of the female non-reproductive body. The three discourses are that of the medical body, of the distressed body, and of the cared for body: within each discourse, specific understandings of the female non-reproductive body arise. The medical body engenders a flawed and passive construction of the female body; the distressed body understands the non-reproductive body as emotionally suffering, and presents the dual association of success with fertility, and distress with infertility; and the cared for body engenders an understanding of a body that, while needing to be passively taken care of by organisations, is also simultaneously expected to exercise a level of agency and proactivity.

Chapter 6 addressed research question 2 and presented the discourse practice level of analysis. Here, the medical body

is shown to engender a relation that sees the organisation as a detached authority and the female non-reproductive body as an object; the distressed body positions the organisation as an 'equal' empathiser and the body as a suffering 'peer'; and the cared for body positions the organisation as a parent and the female body as a child. The chapter showed how the three relations are imbalanced, in that organisations construct the female non-reproductive body as in need of organisational intervention. Thus, organisations at the FCE employ discourses of the body to have the 'upper hand' when relating to the prospective patient.

Chapter 7 addressed research question 3 and presented the research outcomes of the social practice level of analysis. It highlighted how the three discourses employed by organisations at the FCE maintain field legitimacy by virtue of reiterating historical discourses that understand the female body as a vessel for future life; that set external social priorities over the woman's life particularly with regards to the potential future life; and that understand the female body as the locus of reproduction management, and thus that foster a sense of individual responsibility while also reiterating the social taboo of infertility. On the basis of this chapter's findings, I further presented 1) how the bodies and relations which emerged in chapter 5 and 6 maintain pragmatic, moral, and cognitive field legitimacy; and 2) that the strategies of adaptation, reiteration, and interruption are employed by organisations at the FCE to maintain legitimacy.

Chapter 8 discussed the research outcomes in relation to the literature presented in chapter 2. I noted how FCEs can be understood as open discursive spaces: whereas FCEs are temporally and spatially bounded, the discourses employed

therein are not. I particularly note how discourses at the FCE maintain field legitimacy by virtue of partly reiterating past discourses that are nonetheless not explicitly employed at the event. Coupled with the imbalanced discursive relations which emerged in chapter 6, this feature makes resistance to such discourses hard to carry out by text consumers at the FCE. I then proceeded to discuss how the discursive strategies I identified work and interact, and specifically argued how 1) adaptation can hide reiteration, and thus make resistance to past discourses even more difficult; and 2) how the strategy of interruption constructs the FCE as a separate discursive space that fuels field legitimacy by virtue of being separate from society, rather than by being constructed as a new discursive space altogether.

Finally, I presented the implications the findings create for the female non-reproductive body and organisation studies. Here, scholars have noted how the maternal body is subject to social and organisational expectations in the workplace (Gatrell, 2013). I discuss that when we include the female non-reproductive body in our reflections, we can see how the permanent duality of social and organisational expectations over the female reproductive body lock the woman in a lose-lose situation: should she reproduce, social expectations of motherhood would be fulfilled, but her productivity would likely be questioned. On the other hand, should she not reproduce, organisational expectations would likely not be questioned, but social expectations of motherhood would remain unfulfilled.

The following section summarises the contributions of the thesis.

9.2. Contributions of the Thesis

The contribution of the thesis is fivefold. First, this thesis contributes to our knowledge of how discourse is generated and employed at FCEs (Hardy and Maguire, 2010). My analysis shows how discourse generates imbalanced relations between text producers and text consumers, and that these imbalanced relations create and sustain the need for organisations at the FCE and in the field. Further, I contribute by showing how the temporal and spatial boundaries of FCEs clash with the openness of discourse: discourses employed at the FCE carry traces of past discourses. These discourses are not explicitly employed by organisations at the FCE, and are thus difficult to challenge and resist. This is because FCEs are limited in time and space, but discourse isn't. I thus argue that, when approached discursively, FCEs can be understood as open discursive spaces, where discourses spatially and temporally seep in and out.

In this regard, the second contribution of this study refers to how FCEs maintain legitimacy through discourse, and thus extends our knowledge on discourse and legitimacy (Vaara et al., 2006). I showed how organisations at the FCE will implement three strategies to maintain legitimacy: adaptation to social norms, reiteration of past discourses, and interruption of social norms. Discourses, then, are not fully generated ex novo at the FCE. I particularly stress how 1) adaptation can hide reiteration, and thus render resistance more difficult to carry out from the text consumer's perspective; and how 2) the strategy of interruption creates and sustains an 'us versus them' dynamic, where organisations at the FCE differentiate themselves from the social environment outside of the field in order to maintain field legitimacy.

The third contribution refers to the inclusion of text consumers in the analysis of discursive legitimacy and of FCEs in organisation studies (Hardy and Maguire, 2010). The study shows how discursive constructions of the female non-reproductive body attending the Fertility Show as a prospective patient are indeed employed by organisations to maintain field legitimacy through the construction of imbalanced relations.

In this regard, the fourth contribution of this study is linked to the application of a CDA approach to examine discourse within the organisational setting of the FCE. I show how a CDA approach explicitly brings to light imbalanced relations, and can thus show us 1) where struggle may take place, and 2) how the use of discourse fosters or hinders power dynamics. What is particularly valuable in this approach is its focus on specific elements of grammar and discourse, and the straightforward intent of bringing out the features in the text that suggest that imbalanced relations are taking place. When approaching FCEs as discursive spaces, CDA provides the researcher with the analytical tools to critically question how discourse works toward the maintenance or challenging of power relations in a spatially and temporally bounded organisational phenomenon.

The fifth contribution sits within the literature on organisation studies and the body. Here, there has been growing interest in the female body particularly with regards to its gendered construction and, within the more specific focus of reproduction, pregnancy and work-life balance (Gatrell, 2011; 2013; Mäkelä, 2005; Malenfant, 2009; Lyness et al., 1999; Halpert et al., 1993; Warren and Brewis, 2004). This thesis contributes to this literature by showing how the female body is subject to organisational expectations and is encased in specific relations with organisations also when not fertile or not

reproducing. The analysis further shows that the social pressure on the female body with regards to reproduction and motherhood are present regardless if the body is reproducing or not. The thesis thus highlights the presence of a lose-lose situation with regards to social and organisational expectations on both female reproductive and non-reproductive bodies: should the body reproduce, it would fulfil social expectations of motherhood while simultaneously unfulfilling organisational expectations of productivity. Should the body not reproduce, it would maintain organisational expectations unquestioned whilst not fulfilling social expectations of motherhood.

9.3. Thesis Limitations

This thesis presents a number of limitations. First, whereas this study contributes to our knowledge of FCEs as discursive spaces, it does not theorise them as generating *multiple* discursive spaces the same way Hardy and Maguire (2010) suggest. Analysing the various discursive spaces at the Fertility Show and the tensions therein (by, for instance, considering seminars and one-to-one interactions at the Show as separate discursive spaces) would add important contributions to the analysis I presented in this thesis. By building on the discourses and relations emerging from my analysis, one could question if and how these are employed by different types of organisations at the FCE. This would in turn foster our understanding of the workings of discourse at FCEs by, for instance, increasing our focus on dominant discourses and dominant organisations, and the implications multiple discursive spaces generate in this regard.

Second, this research highlighted how external expectations seep into the organisation field, however the process is by no means unidirectional (Suchman, 1995).

Investigating how organisational constructions *seep out* of discursive spaces and influence external social environments would provide strong insights as to how processes of legitimacy maintenance take place within and outside of the organisational domain.

The third limitation points at the lack of women's voices and experiences in my study. I have looked at the discursive constructions of the female non-reproductive body from an organisational perspective, but feminist scholars have stressed the importance of beginning analyses from women's lives (Stanley and Wise, 1993; Skeggs, 2001). Investigating women's experiences and motives with regards to fertility treatment would provide valuable insights as to if and how the organisational discourses I have presented in chapter 5 and 6 are being accepted, rejected, or challenged.

Fourth, the research took an organisational perspective and investigated organisational legitimacy. However, a perspective centred on agency would greatly complement the thesis' findings. How do women whose bodies are at the centre of organisational activities construct their non-reproductive bodies? What discourses do they draw upon to legitimise certain organisational practices onto their bodies? Do such discourses match the ones organisations have been found to employ in this study? And if they don't, what are the reasons underpinning such discrepancies? The three discourses and relations I have presented happen on both organisational and individual fronts: organisations surely employ such discourses to maintain legitimacy to operate onto the same body they construct, but people accessing fertility treatment and attending the Fertility Show do seek organisational intervention in order to have

children. This is an important aspect to consider in order to complement this thesis' findings.

The fifth limitation is methodological and refers to the use of CDA, which requires significant focus and depth of analysis, often with respect to a selected number of texts. Other approaches would provide investigations with a wider breadth, particularly when approaching organisational fields as units of analysis. I also recognise that my interpretation of Fairclough's approach to CDA is seldom found within organisation studies: I thus acknowledge that a more 'traditional' use of his framework would have likely led to different reflections. Further, the employment of interviews could offer significant contributions, particularly with regards to the third and fourth research limitations I have identified.

9.4. Suggestions for Future Research

In this thesis, I discussed how the temporal and spatial boundaries of FCEs make resistance to certain discourses arguably hard to carry out. Indeed, analysing discourses at the FCE level can show us imbalanced relations accepted at the field level - but how do we resist them? Is resistance only implementable at the field level, or can effective resisting discursive spaces be created at FCEs? Future studies might explicitly examine FCEs as generating resisting discursive spaces, and move the analytical lens away from organisations to include whoever might resist particular organisations, the FCE, or the entire organisational field.

Further, as mentioned in the previous section, this thesis looked at the female body from an organisational perspective, but from a feminist perspective it is important to begin our analyses from women's lives (Stanley and Wise, 1993). Future

research would benefit from focusing on the experiences of the women whose bodies are involved with organisations through fertility treatment. Importantly, this would entail embracing the varied spectrum of identities and ways in which women access such field: that is, investigating not only medically infertile women, but single women, lesbian women, and 'older' women too. Future feminist research could also take an intersectional perspective and look at how cultural, ethnic, and religious differences account for different experiences within the field of fertility treatment. This would address Byron and Roscigno's (2014) concern with regards to studying differences among women.

Another area for future studies refers to men's bodies and masculinity. Particularly within fertility treatment, men's bodies arguably have been left at the margins of public discussions and concerns. Organisation studies concerned with masculinity could investigate organisational constructions of masculinity with regards to the infertile male body, as well as social expectations of fatherhood, particularly in line with changing social norms on the family. With respect to the data presented in this thesis, we might want to ask how the male body is constructed within fertility treatment. Indeed, we could ask if the male body is at all present, or if instead what is of concern to organisations in the field is only the parts of it that would allow the female body to become pregnant. I think there are important implications on masculinity and fatherhood that we could reflect upon in both cases.

Further, more research is needed with regards to the role of business in reproductive health. How is businesses' bottom line impacting how motherhood is understood, and how is it influencing how the female body is constructed, addressed, and

treated? Is there any room for business practices able to disrupt the strong historical links between biology and gendered social expectations of motherhood?

Linked to this point, another question we might ask is whether the strategy of adaptation opens spaces for resistance to gender norms instead of only hiding reiterated past discourses. In the case of fertility treatment, organisations offer their services and products to same-sex couples in adaptation to current social norms that view same-sex partnerships as socially accepted, and disrupt the historical view that heterosexual partnerships are the main locus where motherhood should happen. At the same time, we might want to ask whether businesses get involved with processes that resist stale gender norms in order to sustain the profit-driven purposes of their field, or if instead moral or ethical motivations towards gender equality are present. With regards to this thesis' specific focus, we might also ask if this can happen through the openness of FCEs as discursive spaces, and/or with the creation of resisting discursive spaces.

With regards to the second limitation of the thesis identified above, future research might indeed question if and how FCEs as discursive spaces are able to influence social perceptions of infertility, non-reproductive bodies, and fertility treatment. For instance, does the temporary interruption of the taboo of infertility emerged at the Fertility Show influence external social norms at any degree?

Finally, the female body has been acknowledged within feminist scholarship as the locus of disruption of gender norms (chapter 2). Important work in the matter is Butler's concept of gender performativity (1990; 1993) which entails that gender,

rather than being set in stone, is always apt to change through action and repetition. However, scholars focusing on women's bodies and reproduction know the uncomfortable co-existence of social construction and biology all too well. This research indeed confirms the long held criticism that when it comes to reproduction, the female body is still understood as a vessel which exists to fulfil stale gender expectations rather than perform its own experience of gender. How can we perform ourselves through our reproductive body, if organisations involved with our biological traits construct us and treat us as vessels? If our reproductive bodies are not socially acknowledged as potentially disruptive to gender norms, but are instead only there to re-produce, what frames can we employ to promote agency and performativity? One way to approach this crucial dualism is to see both sex and gender as socially constructed (Fausto-Sterling, 2000). This would entail a stark new approach to the study of the reproductive body within the organisational domain.

9.5. Personal Reflections and Concluding Remarks

"E' ora di lasciare il canneto	"It's time to leave the stunted cane
stento che pare s'addorma	that seems to be dozing off
e di guardare le forme	and observe the forms life takes
della vita che si sgretola."	as it disintegrates."

E. Montale, 'Non Rifugiarti nell'Ombra' / 'Don't Escape into the Shade'
Ossi di Seppia / Cattlefish Bones, 1925

Part of a critical approach to what we study is encased in the willingness to disrupt and challenge how we think, we act, and we write. I find this true also with regards to academia and academic writing. This thesis came together over a number of years where much happened within and outside of my academic life: some chapters of my life ended, others began, important people came and went, and a lot changed.

Within organisation studies focused on the body, the concept of embodiment is sometimes referred to as the disruption of the duality mind/body, but also of boundaries (Dale, 2001). Thus, I am not separated from my experience of this research, this thesis, or this writing. This document is the product of a lot of work, but it also significantly bears witness of my life during the past few years. I initially chose the topic of fertility treatment because, given the UK landscape, it represents a positive example of how we can challenge obsolete gender stereotypes and parental archetypes. Same sex couples, single women, and 'older' women can all access treatment and in some cases NHS funded treatment. My involvement with gender issues, however, began some time earlier, when I first discovered feminism and, later on, feminist scholarship on the female body and reproduction. With this discovery, I also realised how the body truly is a contested terrain (Grosz, 1995) where political decisions are made, resisted, or disrupted. What we do with and through our bodies, as well as our experience of it, is of great importance to gain awareness of ourselves as agentic and political beings.

Whenever I happen to introduce somebody to feminism, I try to remember how it felt to open my eyes and see, hear, and feel everything much differently. Perhaps in an attempt to protect them from what I can only describe as a 'feminist aftershock', I tell them that after discovering this 'new' reality I lived in a state of inertia for a couple of weeks: nothing made sense like it did before, everything seemed very wrong, and I felt very powerless about it. I did not know what words to speak, or how to react. How was I going to behave with myself, my friends, my family, my partner? How was I talking to myself in relation to my body? How was I treating my body? How much

had I judged other women for their bodies and reproductive lives, and how much had I been judged by society in turn? Why had I done this for so long? What made me feel entitled to diminish myself and other women to objects that had to be made smaller, quieter, and obedient to rules over which I never had any decisional power?

It felt like everything I knew had been demolished, and all I was left with were all these pieces, these fragments that I had now to put together to create something better. Something fair. This feeling subsided, but that fire kept on being reanimated throughout this PhD: from reading key feminist texts, to my decision of leaving the fieldwork earlier than anticipated because it made me so emotionally upset I could not bear to spend another minute in that room (see section 4.12). Data analysis also worked as gasoline to that (growing) little flame: the way childless women were being talked about, but even more so how women ended up soaking up certain discourses and talking about themselves and each other within the texts I analysed, made me realise how much work there is still left to do.

I am deeply thankful for all I have learnt: all the confusion, the pain, and the rage took me through a flourishing path of self-development that I would have never walked had I chosen a different, less challenging topic. I am also deeply thankful for all that I have yet to learn, and for all that is left to challenge, disrupt, and recreate.

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APPENDIX I: Selected Organisations and Data for Text Analysis

Organisation	Type of Organisation	Type of Document and Date of Collection	Number of Documents
Healthcare at Home	Business	Leaflets	2
Herts and Essex	Private clinic	Booklet and Leaflets	1 booklet, 11 leaflets
British Infertility Counselling Association (BICA)	NGO	Leaflets	19
Pride Angel	NGO	Leaflet	4
Fertility Plus	Private clinic	Leaflet	1
Fertility Astrology	Business	Leaflet	1
Bourn Hall Clinic	Private clinic	Leaflets	4
Fertility Road	Press	Magazine	2 issues
Poundbury Fertility	Private clinic	Leaflets	3
Gennet City Fertility	Private clinic	Booklet	1
The Fertility and Gynaecology Academy	Private clinic	Booklet and Leaflets	2 Booklets and 2 leaflets
Infertility Network UK	NGO	Magazine	4 issues (#40-#43)
Infertility Network UK	NGO	Website http://www.infertilitynetworkuk.com/	1

Care Fertility	Private clinic	Booklet, leaflet	2
Progress Educational Trust PET	NGO	Newsletters	63
HFEA	Government	Booklet	1
Simply Healing Centre	Business	Leaflet	1
The Lister Clinic	Private clinic	Leaflet	1
Boston Place	Private clinic	Leaflets	2
Newlife	Private clinic	Leaflets	3
HFE Act 1990	Government	Law	1
HFE Act 2008	Government	Law	1
NICE Guidelines	Government	Policy	1
HFEA	Governmental Body	Website http://www.hfea.gov.uk	1
Warnock Committee	Government	Report	1
AceBabes, part of Infertility Network UK	NGO	Website http://www.infertilitynetworkuk.com/ace_babes	1
More to Life, part of Infertility Network UK	NGO	Website http://www.infertilitynetworkuk.com/more_to_life	1

British Fertility Society	Professional organisation	Website http://www.britishfertilitysociety.org.uk/	1

Total number of organisations included in text analysis:

10 private clinics
3 NGOs
1 Government (HFEA)
2 professional associations
5 Other businesses

APPENDIX II: Pre- and Post-Analysis Coding Process

***Pre- Analysis Orders of Coding*:**

1st order of coding ***Discursive Constructions: Concepts and frequency***	**2nd order of coding** ***Discursive Constructions: Common themes and frequency***	**3rd order of coding** ***Discourses of the Body***
Words used in relation to the body in its physical, gendered, familial, and patient features.	*Frequency, similarity, interpretation of categories.*	*Themes' similarity, frequency, and interpretation.*
Deductive macro categories of the body: Macro category #1 - Inductive micro categories Macro category #2 - Inductive micro categories Macro category #3 - Inductive micro categories	*Thematic group 1* Discursive Construction A Discursive Construction B Discursive Construction C *Thematic group 2* Discursive Construction A Discursive Construction B Discursive Construction C *Thematic group 3* Discursive Construction A Discursive Construction B Discursive Construction C	*Discourse 1* Body A *Discourse 2* Body B *Discourse 3* Body C

Adapted from Gioia et al., 2012.

Post-Analysis Orders of Coding:

1st order of coding ***Discursive Constructions: Concepts and frequency***	**2nd order of coding** ***Discursive Constructions: Common themes and frequency***	**3rd order of coding** ***Discourses***
Words used in relation to the body in its physical, gendered, familial, and patient features.	*Frequency, similarity, interpretation of categories.*	*Themes' similarity, frequency, and interpretation.*
Disembodied Body - Animal - Dysfunctional - Examined - Fragmented - Personal *Gendered Body* - Awareness - Conflation - Neutrality - Normative body - Sex *Familial Body* - Emotional distress - Future life - Success and happiness *Patient Body* - Cared For - In Control - Helplessness - Self-care	<u>Thematic group 1</u> Animal Examined <u>Thematic group 2</u> Distressed Successful <u>Thematic group 3</u> Cared For Self-care In Control	<u>Discourse 1</u> Medical body <u>Discourse 2</u> Distressed body <u>Discourse 3</u> Cared for Body

Adapted from Gioia et al., 2012.

APPENDIX III: Field Notes Collected at the Fertility Show in 2013 and 2014.

Organisation	Type of Organisation	Date of Collection	Number of Pages
The Agora	Private clinic	Seminar field notes	2
Me	-	Reflexive field notes	6
Counsellor at London Women's Clinic, The Bridge Centre, and volunteer at Infertility Network UK	Private clinics	Seminar field notes	2
Infertility Network UK	NGO	Seminar field notes	3
Bourn Hall Clinic	Private clinic	Seminar field notes	2
Fertility Plus	Private clinic	Seminar field notes	1
Herts and Essex	Private clinic	Seminar field notes	2

Field Note Sample:

SEMINAR: *Fundamentals of infertility*
Group Medical Director, Bourn Hall Clinic

Room is full. This feels like an educational talk (self-care). They have 3 clinics.

The doctor doesn't want to talk to us like 'birds and bees', or in a 'highly scientific' tone. It's difficult to pace as a talk because 'we' are all at different stages.

He shows us "The team that brought hope" picture of the birth of the first IVF baby, with the medical team present at the moment of birth: Dr. Patrick Steptoe (gynaecologist), Jean Purdy (nurse), Louise Brown (IVF baby), Prof. Sir Robert Edward (Scientist).

In his PowerPoint presentation, he shows us that natural conception depends upon:
Healthy sperm
Healthy eggs
Open and functional fallopian tubes
Normal uterus

Sperm: picture of how it is supposed to look. Should be able to move forward and travel through the tubes to reach the womb and implant into the egg. Sperm have different sizes and shapes. Human males are the worst male mammal re sperm quality, but the quantity is huge and enough to fertilize the egg.

Human egg: he shows us a picture of "a beautiful human egg". In IVF, they look for signs of fertilization. Picture of fertilized egg 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".

After day 5 embryo hatches out of the shell and implants in the womb. "where are the parts where things go wrong?" He says infertility is very common (1 in 6 couples). Fertility checks include:
Sperm – semen analysis
Eggs – blood tests and scans to check egg quantity and quality
Tubes – scans
Womb – physical examination/scans

When women are female foetuses in the womb, they are given the amount of eggs for their lifetime, then it diminishes.
Some women are born with less amount of eggs than normal. If FHS level is up in the tests, then the eggs are failing. He describes the tests that can be taken to know ovarian reserve (AMH, that can be done at any time during the cycle). When talking about the tubes he says that "we look into your tummy and tubes" through laparoscopy, and "your womb".

N: I notice that the personal body comes up at the Fertility Show and during talks in particular, but doesn't maybe come up as much in leaflets or other marketing materials? Maybe check NGOs and support groups.

List of fertility treatments: ovulation induction (through clomiphene or daily injections), IUI, IVF, frozen embryo transfer (FET), ICSI/IMSI, surgical sperm recovery (when man produces sperm but doesn't ejaculate), donor sperm / eggs, egg /sperm donation, embryo donation, IVF surrogacy. Some clinics do ovarian stimulation together with IUI. IUI success rates are "extremely disappointing". IUI is more for couples who can't have sexual intercourse.

Women – age – after 35/37 sharper drop in fertility. This is "normal physiology", and it is "unfair" that men can produce sperm all their lives. His advice is to take time into account, after 37 go for IVF rather than other treatments, as there are more chances with IVF.

IVF carries risks of multiple pregnancies, which are a hazard for both mother and baby. They encourage single embryo transfer (it can always split into 2 and give you twins) but multiple embryo transfer will increase chances of multiple births.

If men have poor sperm quality, they use ICSI, where they take a single healthy sperm and inject it into the egg. Same success rates as IVF (he says "excellent success rates"), more advanced technique is IMSI (magnifies the sperm even more to see it more clearly). He says that "having been through the pain of infertility", most men will be happy to use their sperm for sperm sharing.

He moves on to talk about IVF surrogacy for women with severe medical conditions. Here a surrogate will carry the pregnancy (embryo transfer). There are specific medical conditions for this, see HFEA regulations on this. The surrogate can decide legally to keep the baby and be the legal parent of it and there is nothing the patients can do about it.

He concludes by listing the prospective patients' choices: Investigation and diagnosis; Explore treatment options; Eligibility for NHS, which he calls a "horrible postcode lottery"; Seek support; and Identify next steps. He suggests to "choose carefully and choose wisely" with regards to private clinics.