

Essay:

Families on the frontier

Author:

Catherine Kevin

When I met Maree Inggall in the foyer of her Sydney hotel, she had travelled from Melbourne to the clinic of Sydney IVF for the third time in as many months.¹ The purpose of the first visit was a general consultation. The second was for egg collection. This time she had had an embryo transferred and was hoping to be in the very earliest stage of pregnancy. Maree is a tall, strong woman, yet sitting in the hotel lounge she had shrunk under her woollen poncho. Her feelings of fragility were obvious as she spoke softly about her reasons for using in vitro fertilisation (IVF) and for coming to Sydney to do so. Maree's embryo had been screened for disease and for sex. She wanted a little girl.

To travel to Sydney was no easy organisational feat for a mother of three young boys. At home in Melbourne with their father were a five-year-old, a three-year-old and a baby. Jackson, Maree's middle son, suffers from a rare and debilitating illness, type-two spinal muscular atrophy (SMA). She told me that some months before, Jackson had put his little head in his hands and, as though finally ready to accept the truth, said, "I can't walk mummy, can I?" When I met with Maree she had recently bought Jackson a new yellow wheelchair. This enlarges his world, nourishing his curiosity in ways previously out of reach. But even to roll over in bed is too much to ask of Jackson's weak muscles and his life is likely to be shorter than any mother could bear. He may survive into adolescence but no one's making any promises. Already the family had faced several crises. One of the worst was a year earlier as Jackson battled pneumonia. Maree was nervous as we talked on the last day of July. The winter sun found its way between the tall buildings of Sydney's CBD, while in Melbourne the weather was bleak. Maree feared the constant cold would pierce Jackson's delicate body and take his life.

After Jackson's diagnosis, Maree and her husband decided they could not take the risk of conceiving another child with this debilitating disease. For her next pregnancy they would undergo chorionic villus sampling (CVS) to test for SMA. Towards the end of her third month a long needle entered her uterus to extract a sample of chorionic villi, the outer membrane surrounding the foetus. The results were to be available in seven days, during which time she had to leave Melbourne to be with her dying father. This meant

that Maree didn't receive the results until two weeks later when she was in her thirteenth week of pregnancy. When Maree and her husband decided that she would take the test they had committed to terminating the pregnancy if the result was positive for SMA. Despite this commitment, Maree described the subsequent termination as the most difficult decision of her life. It was made worse when they discovered that she was carrying a female foetus. Her three boys are beautiful but to have a little girl now seemed like the greatest prize. Pre-implantation genetic diagnosis (PGD) and its legal status in New South Wales in 2004 enabled Maree to pay Sydney IVF to select her embryo for sex as well as disease. That is, to do all within the current reach of science to ensure she avoided a pregnancy she would terminate and instead carry her tiny prize.

Maree's account is one of many that tell a hopeful but thorny story. Together, these accounts make up a larger story of social and conceptual change. Medical technologies that make it possible to select embryos for the quality of their health and for their sex raise the spectre of eugenics. We have not only history but science fiction to feed our capacity to imagine a world in which eugenics provides the guiding principles.² For the many of us born before 1990, when Lord Robert Winston's London team first successfully selected an embryo in this way, it is unsettling to consider our own births and wonder whether we would have carried the genetic traits to warrant selection.³ But while Maree tells the story of the happy sense of possibility that PGD has provided her, my nervous wonderings fall away and I keenly join her in hoping for the success of her treatment; for the selection of what will become a healthy little girl.

Modern reproductive technologies create new dilemmas, but also new kinds of hope for many families in contemporary Australia. By "technology" I mean not simply commercial scientific activity, but the organisation and deployment of resources for a desired end. This includes both PGD (and its necessary accompaniment, IVF) and self-insemination. In this article I look closely at families on the technological frontier, specifically through the eyes of mothers. In particular I'm interested in the new ways in which women understand themselves as political subjects, in the light of their experiences. There are a number of historical narratives that are relevant here. One is that of the female body as a site of public moral anxiety. Historically, and broadly speaking, women have struggled to hide and terminate pregnancies for fear of revealing transgressive heterosexual encounters. More recently, the pregnant body has evoked anxiety focused on alternative modes of conception that separate sex and pregnancy. Anxieties coalesce around women's ability to become pregnant without sexual relationships with men and beyond their fertile years, and around women's new power to remove some genetic characteristics of their progeny by having their embryos screened, giving them some power to shape the genetic future.

A second narrative is that of bodies transformed by the processes of conception: bodies that are tested and drugged, that are subjected to extractions and implantations. It is a narrative about those who struggle to become pregnant and must approach their attempts at conception – whether high-tech or low-tech – and their “at risk” pregnancies with great vigilance. The widespread publicising of new reproductive technologies has exposed the reproductive workings of the body in unprecedented ways, embellishing our imaginations with new biological details.

Coupled with this story is that of women’s internalised surveillance in pregnancy. More than half a century of conventional antenatal-care practices have produced self-policing women, women who understand the science of their pregnancies and take responsibility for providing optimum uterine conditions.⁴ Since 1978, when Louise Brown, the first “test-tube baby”, was born, women who use IVF or self-inseminate have developed a detailed knowledge of their cycles, an awareness of their body’s idiosyncrasies, flaws and changes, and a history of its disappointments and achievements. Early in my conversation with Maree, she gave a description of “seeing” the beginning of her pregnancy, prior to her conception and weeks before a foetal ultrasound that placed her experience firmly in the 21st century and at the technological frontier:

Because I’ve seen her, I’ve got the picture of the cells, the embryos ... I’m sort of imagining now that she’s embedded, hopefully, in my uterus. It’s strange, like when I walked out that door the other night, I felt like nobody knows what’s happening to me and what’s going on inside, everybody’s just going about their business and I thought, “Hey!”

For Maree, this moment felt somehow incongruous, its invisibility out of step with its significance and in her mind’s eye.

A third narrative within the modern history of reproductive technology is that of public debate. Important contributors to this debate are surely women who use the technologies in question and feminists who take the positions of these women seriously and incorporate them into their critiques. In the 1980s and 1990s, feminist critics were prominent in the Australian debate about the pros and cons of IVF. Renate Klein and Robyn Rowland, for example, began publishing, teaching and organising political action around their radical feminist critiques of assisted reproductive technologies in the mid-1980s. In 1992, Rowland published *Living Laboratories* (Sun Books) and Klein *The Ultimate Colonisation* (Spinifex). The powerful metaphors contained in these titles pointed to what these authors believed were the dangerous disembodiment effects of reproductive technologies on women.⁵ The positions of feminist interlocutors have been more refracted in recent years but are characterised by a critical examination of the long-term

impact of reproductive technologies on definitions of maternity and family. Both the generalised histories of controversy and women's individualised experiences must now be balanced in an analysis of the reproductive frontier.

It is also surely legitimate to integrate emotional responses into an intellectual consideration of the issues that PGD and its various applications raise. Belgian philosopher Isabelle Stengers speaks of the importance of encounters with people and ideas that force us to feel and, by extension, to think anew.⁶ The importance of individual narratives in political debates is by no means a revelation, particularly in the context of feminist scholarship, but my interview with Maree reminds me of the complexity of navigating one's emotional responses and established thinking on an issue in the process of coming to something that approximates a position. Such encounters are our best chance of encapsulating at least some of the specificity of women's lives when they come to engage in reproductive technologies, as well as engendering curiosity and openness. As Jackson's mother, Maree is all too aware of the sadness that SMA brings into the lives of families. She is among a number of Australian women who can speak both as a user of new reproductive technologies and as one who lives with a condition that such technologies can prevent. Of course, she would never replace Jackson but to continue expanding their family with the risk of passing on SMA again is a prospect that is too painful for her to bear. And when it comes to sex selection, the particularity of Maree's story forces me to rethink my previously negative position in terms of its possibilities to heal.

In 2004, when I interviewed Maree, Australians were far from resolved about where they stood on these issues. As we spoke, Sydney was the city to go to if you wanted to use PGD to choose the sex of your child. Clinics in that city performed the procedure in the name of "family balancing". More recently, a federal government-initiated ethics committee was appointed to look specifically at sex selection. In March 2005, it recommended that National Health and Medical Research Council (NHMRC) guidelines, the main source of regulation for NSW, prohibit the treatment "pending further community discussion". As a result, all services for sex selection in Australia have been suspended.

It is important to note that no mechanism for community consultation was established to inform the committee, which no doubt led to the open-ended recommendation. While Sydney IVF and IVF Australia have joined the NHMRC-based committee in calling for public debate on the issue, the Minister for Health, Tony Abbott, seems unlikely to revisit the question. This is despite his acknowledgement that community views on the practice are unknown. Legislation in the United Kingdom banned sex selection in 2003 and it was not available in the other states and territories of Australia when Maree had her embryos screened. Victoria has the most comprehensive *Infertility Treatment Act* in Australia,

passed in 1995, which specifies legal access to PGD for selection against disease only. Western Australia has lagged behind Victoria and many other states when it comes to this application of the technique. Only in June 2004 did the West Australian Parliament pass amendments to its *Reproductive Technology Act 1995*, which meant that, for the first time, West Australian women could use PGD in their state to screen for disease.

Jenny and Robert Davies are from Perth. Their son, Isaac, was born in early 2004. Robert suffers from polycystic kidneys, a condition that took his grandmother's life. It then took his mother's life when she was 61, after two renal transplants and years of disruptive and painful dialysis. Robert's sister suffers from polycystic kidneys and there is a 50 per cent chance that her children will as well. When I met Jenny and Robert they had been a couple for eighteen years and had been married for fourteen. She is a physiotherapist and he a doctor. Jenny's telling of their story is imbued with the optimistic rationality of someone who possesses a confident medical understanding of the body and familiarity with the health-care setting. Her background seems to enhance her ability to find comfort in the possibilities of science, and in hospitals and clinics, amid the rigorous application of scientific methods to her body. Jenny is also adept at isolating the moments of ethical struggle that she experienced during the course of her journey to motherhood. Before contemplating the expensive and logistically complicated course of PGD, Jenny and Robert set up the procedure for CVS to test for polycystic kidneys when Jenny became pregnant. As in Marea's case, this would have involved seriously considering a termination if the results were positive for the condition. Before this difficulty was faced, Jenny realised that she and Robert were unable to conceive without assistance. In Jenny's words: "This sat much better ethically with us."⁷ This way an abortion decision was avoided and, rather than choosing PGD from the start, the need for IVF (the procedure integral to embryo screening) was established by the limits of Jenny and Robert's capacity to conceive.

Had they lived outside of Western Australia, Jenny and Robert would have approached an IVF clinic and begun the groundwork for PGD – counselling and blood sampling – soon after infertility was established. Instead, they entered the difficult terrain of pursuing access to a medical technique that was illegal in their state. Jenny expressed the frustration they both experienced due to their status under West Australian law at the time of Isaac's conception and birth. This frustration translated into politicisation.

One aspect of their political trajectory related to funding. As a medical specialist, Robert was aware that the Department of Health in Western Australia provides funds to people who must travel in order to receive treatment that isn't available in the state. Jenny and Robert were set to take advantage of this provision when their anger about the legal status of PGD was exposed in the West Australian press. The money was withdrawn.

Jenny believes that political pressure forced the West Australian Health Department to take back its promise of financial support. Jenny explained to me soon after Isaac's birth and before the change in the law, that she and Robert persisted in seeking this support and publicised their campaign in the interests of other couples who at that stage may not have been able to proceed with treatment without it.

Finding a public voice to express their views on the issue of PGD came at some cost to Jenny and Robert – including the loss of financial assistance. But it has generated advantages as well. While, previously, Robert had been private about his condition, it is now common knowledge among their friends and colleagues. This has been liberating to some extent and has increased people's understanding of Robert's approach to life and decisions he and Jenny have made as a couple. The publication of their story also added to the campaign to change the law in Western Australia. Being spokespeople for PGD has taken Jenny and Robert into public arenas where they have faced questions about their use of the technology and have been asked to reflect on its various meanings in the wider community. Jenny told me that "a lot of people have questioned us ... they've said, 'this is not a disease that will wipe you out at 20' but for us, it's too much of a burden".

In a discussion on SBS Television's *Insight*, Robert described PGD as "some of the very best technology and modern medicine in practice".⁸ He spoke of its power to halt the transmission of polycystic kidney disease to future generations of their family; to stop it in its tracks forever. For Robert, who suffers from the disease, PGD is about changing the course of history.

For Kath Duncan, a disability activist and another discussant on the program, Robert was effectively claiming that he should never have been born. Kath lives with congenital limb difference, which means her right leg and left arm are half as long as their corresponding limbs. For her, public discussion has not dwelt adequately on the value of human experiences of interdependence and the construction of definitions of disability. Kath argues that acknowledgement of the significance of these phenomena is lost in the rush to take advantage of the new conceptions that PGD makes possible. On *Insight* she suggested that in our social responses to a child with polycystic kidneys or SMA we need to be much more conscious of the power we have to determine the value of bodies and therefore shape the lives lived through those bodies we define as disabled. She said, "The problem is not my body ... it's society ... We need to think about on what basis these decisions are made."⁹ Kath's is a call to slow down what she worries is the approach of the normalisation of PGD and therefore the return of a more marginal status for those living with bodies we describe as diseased and disabled.

One response to this is the call for procreative autonomy. In the context of assisted conceptions and embryo screening, a discourse of procreative autonomy has been perpetuated by spokespeople for the industry, women and couples who have used the techniques and some medical ethicists. Most recently, the debates in which this position has been articulated have tended to focus on the use of technologies to screen for sex, disease and disability. It also has an important place in debates about single women and lesbian couples and their occupancy of the reproductive technological frontier. There are, of course, a number of approaches to conception used by those wanting to become pregnant without sexual intercourse. In Australia, women have arranged self-insemination privately and through sperm banks and some clinics.

There are also women who have faced the disappointments of infertility and used IVF to conceive their children, though this has been legally fraught in some states, most memorably in Victoria. In August 2000, a controversy erupted in Melbourne that made waves in the media for more than two years. The case of Leesa Meldrum, single and seeking pregnancy, refocused the IVF debate on the question of who is entitled to bear children. Meldrum successfully challenged Victoria's 1995 *Infertility Treatment Act*, which was found to be inconsistent with the *Federal Sex Discrimination Act* in refusing her access to treatment on the grounds of marital status.

Prime Minister John Howard claimed that changes to the federal act would express concern for the rights of the child who would be disadvantaged in lesbian or single-parent families. When Howard first proposed the changes, the federal opposition described his agenda, as "an assault on the human rights of women in Australia".¹⁰ In 2002, the case went to the High Court where the Catholic Bishops' Conference challenged the 2000 ruling and lost. This was seen as a loss for the Catholic Church and the government and Howard threatened to give the states powers to restrict treatment for single and lesbian women, reasserting his investment in what has been called a "preferred parent model". As this two-year furore made clear, this potential for "wilful" single motherhood and lesbian parenting – both at the technological frontier – throws up questions about the definition of fertility and evokes deep anxieties about what might come to be defined as a family and women's recent sources of power to control this.

Relevant here is a new language of conception that has entered our lay-scientific vocabulary: "IVF", "turkey basters", "sperm donors", "designer babies" and other terms employed to invoke stories of alternative conceptions are used with increasing ease and frequency. This language enables a new reproductive body to emerge in the public imagination. This comes fraught with new public anxieties as well as profoundly shaping the experiences of women who become pregnant using these techniques. This language also has the potential to leave its trace on the families being formed at these scientific and social frontiers.

Deborah Dempsey has recorded the varying ways that lesbian couples speak about their relationships and the role of self-insemination in their coming to parenting. She has argued that despite the claim that alternative methods of conception are producing a new reproductive discourse that separates sexual activity from reproduction, couples' self-insemination stories "demonstrate moves towards the naturalising of lesbian sex within reproductive narratives, as part of an ongoing quest for the legitimacy of lesbian parenthood".¹¹ By contrast, the narrative of Margie Roland (not her real name), a single lesbian mother who self-inseminated, supports the claim regarding the new reproductive discourse.¹² Fitting her story into a nuclear family narrative is less possible in the absence of a lesbian relationship, but her desire for Andrew, her child's biological father (as Margie calls him), to have a relationship with her child would have destabilised this anyway. For her, a family is enabled by the practice of self-insemination and does not suffer the burden of its unique design but rather is shaped as a success story.

In terms of the production of new bodies, I'm interested in exploring how Margie's approach to conception affected her understanding of her own body. At the time Margie was trying to become pregnant, Andrew lived in Sydney and she in Melbourne. After seven months spent on what she calls "an emotional roller-coaster", and seven interstate trips to attempt conception, Margie became pregnant with her child. This was not her first pregnancy. She had conceived twice before but the pregnancies were short-lived. So short were they that Margie resists the term "miscarriage" to describe these events, preferring to call them "pregnancies that didn't hold". Only because of Margie's detailed knowledge of her body, her constant self-monitoring and keen awareness of the slightest change in her temperature, did she know she was pregnant, and then not pregnant, on those first two occasions. Another significant factor for Margie was age – she was 40. Perhaps one of the most irritating aspects of the professional management of her pregnancy was hearing frequent concerned reminders of her advanced age and the risks it could present. These came in spite of her good health and her conscientious and knowledgeable awareness of her pregnant body. Similarly, when Amanda Collinge was struggling determinedly down her path to a family, she was forced to contemplate her age and was intensely aware of her body – of the changes it was and should have been undergoing, and those that had already been wrought by age. It was not until she and her partner, Frank, had made the decision to adopt a child and lessened the intensity with which they were attempting pregnancy that her awareness lost its sharpness. Ironically, this was when she became pregnant.

Amanda has a striking story to tell.¹³ It speaks directly to many of the themes that are relevant to a historical and feminist discussion of reproductive technology.

Amanda always knew she wanted children of her own. She is an eldest child and spent much of her childhood and adolescence caring for her siblings. So, like many eldest children, particularly girls, she had some idea of the travails and pleasures of parenting. After relationships in Australia and in Europe with men who didn't want children or wouldn't agree to raise them in Australia for any period of time, Amanda met Frank. She was 36 and he was much younger. Their age difference meant Amanda felt that she needed to communicate early and directly to him her focus on having children. After some serious consideration Frank committed to Amanda and accommodated the prospect of children within that commitment. They now have three children. When I interviewed Amanda at the end of 2004 her eldest was three years old. So it was five years between the beginning of her relationship with Frank and the birth of their first child. I tell Amanda's story here because, like so many tens of thousands of Australian women, reproductive technology finally assisted in the creation of her family.

At the first clinic that Amanda and Frank went to she was treated by a doctor she describes as a "cowboy". During her first cycle she was given too much oestrogen and suffered from serious hyper-stimulation. In the worst cases of this condition women's ovaries become extremely swollen and fluid accumulates in the abdomen and chest, causing abdominal pain and shortness of breath. According to the literature Amanda had read, this only occurs in 5 per cent of cases so she felt relatively safe from harm. Unfortunately, her confidence proved to be misplaced. Seventeen eggs were extracted during that cycle but by the time she came into the clinic for embryo transfer she was swollen with bloat, so large that her friends had been to her home to make videos of each other taking her measurements. Amanda laughs at that particular memory but is keen to convey the danger that she was in, the terrifying nature of her condition and the clinic's lack of regard for her wellbeing despite her inability to move independently from the car into the waiting room. After this episode, which could have seen her spending Christmas in an intensive-care unit, her doctor suggested they inject Amanda with the same levels of oestrogen again – endangering her health to the same degree. Amanda and Frank knew the risk was too great and so they decided to go to what was probably the most highly regarded and most expensive clinic in NSW.

Another pertinent thing about Amanda's story, which places her at a turning point in the recent history of IVF treatment in Australia, is her pregnancy with twins. Nicky and Daniel were one at the time of our interview. Today, Sydney IVF and IVF Australia categorise twin pregnancy as a risk. Similarly, the Monash IVF website notes: "Management of IVF in Australia is characterised by a very careful approach to embryo transfer, in order to reduce the likelihood of multiple births." Britain's fertility treatment regulators are reviewing whether they should follow other European countries in making single-embryo transfer the norm.

In 2003, when Amanda's daughter Lucia was twelve months old, Amanda rang the clinic to ask for advice about becoming pregnant again. At this point, Lucia was sleeping badly and had had some feeding problems. Her parents were besotted with their longed-for daughter but Amanda describes these glitches as a reality check. They had talked for years about having three children but Amanda had begun to think she may only want two. There were three frozen embryos left after the last cycle and on her request for advice she was told not to delay her next visit to the clinic. At 42, the clinic informed her, there was little time to spare. Amanda reflected on their handling of her case:

In my belief, the first bad advice was to do the cycle then and there, because Lucia was only twelve months old. And secondly, the thing that they did that I think was poor, which they no longer do so it makes you feel like a guinea pig, is they put back two. The day they did the transfer I started to really think about this putting back two and I remember I went in there and I went: "Look, I've got a baby at home and she's only twelve months old, she's a baby, and you know, maybe you should just put back one."

Amanda was told not to worry; that she would be lucky if she conceived at all. Amanda and Frank became convinced that she wouldn't that time, but before long they learnt that Amanda was not only pregnant, she was pregnant with twins:

I'll never forget that car trip home. ... I just bawled my eyes out ... I felt really bad for her [Lucia] and I just knew, I just knew everything it was going to be, which it was. I was quite right. But I felt really angry about that lack of, that really unthinking attitude you know, just whack 'em in and not think it through and not sit down and talk to us about it. And we should have been more on top of it. We should have specified. Because we could have just put them in one by one. And you know within months of that, they stopped doing it ... particularly if you already had a child, they stopped putting in two ... so it's very experimental. But see that's what you actually get involved in.

Amanda was the first woman I interviewed about reproductive technologies who initiated a discussion of feminism. When she and Frank were forced to confront their need for IVF, Amanda was horrified. She had what she describes as "a lot of feminist suspicion and distrust of the IVF industry". She'd read the work of radical feminists who accused the industry of preying on vulnerable infertile couples and suspected that IVF causes long-term damage to women's health. Amanda decided she had to "put all that aside". Her desire for a child was so great and, given all the work that she had done attempting to bring children into her early relationships and protecting her fertility, it would have been more difficult to turn her back on her remaining hopes for pregnancy than refuse IVF. For Amanda, who had identified as a feminist for two decades and had long been part of feminist communities, the political dimension of her experience was not about legal access, as it was for Jenny Davies. Instead, it was about the tension between her feminist-informed suspicions of the IVF industry and her desire to bear children.

Some of Amanda's suspicions, which initially had to be set aside, were confirmed by her experiences. I would also argue that her original suspicions endowed her with a caution that helped her to negotiate the first clinic. They have also given her a language in which to understand and articulate her negative experiences, incorporating them into her story of successful IVF. This nuanced position on reproductive technologies continues to inform her feminist practice as a journalist and writer.

The collective reproductive histories of Amanda, Margie, Jenny and Maree raise many questions about the power of alternative methods of conception to change the experiences of maternity and the social meanings of pregnancy. The steps involved in each procedure potentially recast individual women's relationships to science and industry, to desire and to established feminist principles, and impact on their sense of the capabilities and purposes of the female body. These increasingly widespread reproductive technologies open up new possibilities for thinking and experiencing the body. These possibilities are produced and limited by the conditions that characterise our moment in history. At their centre are the hopes and dilemmas they generate for women and the communities in which they live.

When considering questions of access, an argument for procreative autonomy is an interesting starting point. Its compelling logic, when applied to abortion debates, posits that women should be trusted to make abortion decisions outside of the scrutiny of criminal law. In the face of the term "autonomy", it has been noted that women's abortion decisions are frequently made in consultation and with a view to how their decisions will affect others, including the child they could bear.¹⁴ The same can be said of women who travel to the reproductive technological frontier. Their individual and complex embodied experiences and their decision-making processes need to be fully considered in future debates about regulation so that the meanings of these technologies are articulated by those whose lives bear their most profound marks. And in the speculation that these debates entail about ways in which current and future uses of reproductive technologies could change the constitution of populations and future social relations, mothers and their families – whichever form they take – must be given room to tell their stories.

These are always emotional debates, regardless of attempts to claim they are purely scientific or philosophical. Individual histories that incite an emotional response leave us open to processes of transformation that loosen and shift our positions. So, as women like Maree and Amanda have found hope at the interstices of their desire and the availability of technologies that have emerged in their lifetimes, those of us concerned by the politics of reproductive technologies can find hope for their best possible deployment at the interstices of our established positions and of life stories. In slowing down to listen, we might achieve something approximating genuine progress.¹⁵ ■

¹ Information contained here about Maree Inggall is based on an interview we conducted in Sydney on July 31, 2004, and a follow-up telephone conversation exactly one year later.

² I refer here to Nazi Germany, the film *Gattaca* (Andrew Niccoll, 1997) and Margaret Atwood's novel *The Handmaid's Tale* (J. Cape, London, 1986).

³ I am mindful of the practice of sex-selected abortion changing sex ratios in favour of boys in countries such as China and South Korea and wonder how this fact should inform our understanding of PGD, particularly sex selection. See Amartya Sen, "The Many Faces of Gender Inequality", *Frontline, India's National Magazine*, Volume 18, Number 22, 2001. I also bear in mind the inadequacy of services for Australians with disabilities and am aware that voices from numerous sides of the debate about screening against disability and disease have raised this issue to argue their point.

⁴ See Catherine Kevin, "A Genealogy of Pregnancy in Medicine and the Law: Australia 1945-2000", unpublished thesis, Department of History, University of Sydney, 2003. For discussions focused outside of Australia, see Lisa Cartwright, Constance Penley and Paula A. Trenchler (eds), *The Visible Woman, Imaging Technologies, Gender and Science* (New York University Press, New York, 1998), Duden, Barbara, *Disembodying Women: Perspectives on Pregnancy and the Unborn* (Trans. Lee Noinacki, Harvard University Press, Cambridge Massachusetts, 1993) and Duden, Barbara, *The Woman Beneath the Skin: a Doctor's Patients in Eighteenth-Century Germany* (Trans. Thomas Dunlap, Harvard University Press, Cambridge Massachusetts, 1991).

⁵ Robyn Rowland, *Living Laboratories: women and reproductive technologies* (Sun Books, Sydney, 1992), Renate Klein, *Radically Speaking: feminism reclaimed* (Spinifex Melbourne, 1996). These voices have been less prominent in more recent debates, though Klein has been interviewed recently for *Sperm Wars*, in which she repeats the concerns that she has held since the 1980s. See Heather Grace Jones and Maggie Kirkman (eds), *Sperm Wars, the rights and wrongs of reproduction* (ABC Books, Sydney, 2005).

⁶ Isabelle Stengers in conversation with Mary Zournazi, "A 'Cosmo-Politics' – Risk, Hope, Change", Mary Zournazi, *Hope, New Philosophies for Change* (Pluto Press, Sydney, 2002).

⁷ Interviews were conducted with Jenny Davies between May and July 2004.

⁸ Robert Davies on *Insight*, SBS Television, first aired August 31, 2004.

⁹ Kath Duncan on *Ibid*

¹⁰ Benjamin Haslem, Sid Marris, Alison Croweller, "PM ignites family row", *The Australian*, August 2, 2000, p1.

¹¹ Deborah Dempsey, "Reproducing intimacy and kinship beyond intercourse: Lesbian couples practising self-insemination", in Maggie Kirkman, Jane-Maree Maher and Kay Torney Souter, *The Fertile Imagination, Narratives of Reproduction*, (special issue) *Meridian*, Volume 18, Number 2, 2002.

¹² Interview conducted with Margie Roland (not her real name) on November 5, 2004. All names in this story have been changed.

¹³ Interview conducted with Amanda Collinge on December 16, 2004. Amanda Collinge has also published an account of her reproductive experiences in Amanda Collinge, Sue Daniel and Heather Grace Jones (eds), *Always a part of me: Surviving Childbearing Loss* (ABC Books, Sydney, 2002).

¹⁴ See, for one example, Leslie Cannold, *The Abortion Myth, feminism, morality and the hard choices women make* (Allen & Unwin, Sydney, 1998) and Mary Poovey, "The Abortion Question and the Death of Man", Butler and Scott (eds), *Feminists Theorize the Political* (Routledge, New York and London, 1992).

¹⁵ I am very grateful to the women who shared their stories with me. In all but Margie Roland's case I have used the real names of the women I interviewed. Initial contact with interviewees was established with the help of fertility clinics, and through people with expertise in the field working outside of the medical profession. When the research was undertaken I was not affiliated with an academic research institution and therefore was not given clearance by any research institution's ethics' committee. All interviewees consented to recorded interviews, were offered transcripts of the interviews, selected whether or not to have their names published and consented to the publication of interview material.