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Screening pasts for healthy futures: Egg donation and the making of the ‘healthy’ baby in Spanish fertility clinics

Zusammenfassung

Per Früherkennung in die gesunde Zukunft: Eizellspende als Weg zum ‚gesunden‘ Baby in spanischen Fertilitätskliniken

Welches Leben gilt als reproduzierbar in einer Reproduktionsklinik? Was ist das spezifische Verständnis von Technologie und Fortschritt und was hat dies mit der Erwünschtheit bestimmter Körper zu tun? Was hat die Eizellspende eigentlich mit Selektion zu tun? Dies sind die Leitfragen dieses Beitrags, in dem ich die Idee des ‚gesunden‘ Babys in der Drittparteienreproduktion in Spanien untersuche. Auf der Grundlage meiner ethnografischen Feldforschung in einer Reproduktionsklinik in Valencia analysiere ich die klinischen Praktiken, mittels derer ‚gesunde‘ Babys ermöglicht werden. Ich argumentiere, dass eine technophile und ableistische Zukunftsvision im Mittelpunkt der Vorstellung eines ‚gesunden‘ Kindes steht. Zudem zeige ich, dass der Einsatz genetischer Selektionstechniken durch Fortschrittserzählungen normalisiert wird und dass die Machtstrukturen einer transnationalen Bioökonomie dadurch (re)produziert werden. Schließlich zeige ich, dass die Praxis der Eizellspende in Spanien nicht nur als assistierte, sondern als selektive Reproduktion verstanden werden muss.

Schlüsselwörter
Eizellspende, Genetische Träger-Screenings, Be_hinderung, Technologiekritik, Bioökonomie

Summary

What kind of life is considered reproducible in a fertility clinic? What is the specific understanding of technology and progress and what does this have to do with the desirability of certain bodies? What does egg donation have to do with selection? These are the guiding questions of this article, in which I explore the idea of the ‘healthy’ baby in third-party reproduction in Spain. Based on my ethnographic fieldwork in a fertility clinic in Valencia, I analyse the clinical practices through which ‘healthy’ babies are produced. I argue that a technophilic and ableist vision of the future is at the centre of this idea of a ‘healthy’ child. Furthermore, I suggest that the use of genetic selection techniques is normalised through narratives of progress and that the power structures of a transnational bioeconomy are (re)produced as a result. Finally, I show that the practice of egg donation in Spain must be understood not only as assisted but also as selective reproduction.

Keywords
Egg donation, pre-conception genetic carrier screening, ableism, technology, bioeconomy

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1 Introduction: Ableism and dis_ability in/justice in fertility clinics

Let me begin with an uneasy comparison made by Elena, a psychologist working in a Spanish fertility clinic:

> "So, to go to a fertility clinic is as you would go to a restaurant and they ask you: 'Do you want the best table, with the best view, the best menu, the best wine? Or do we give you a table just wherever?' If you have those options, what do you choose? Do you choose just the first table they give you, or the table in which you have all the guarantees that you will have a great evening? That's the issue. Science gives you the choice, and if you can choose, well you will choose." (Elena, clinical psychologist, Valencia, 2018)[1]

Elena compares the ethical dilemma of having 'healthy'[2] babies through assisted reproduction with the much more mundane situation of visiting a restaurant. What does it mean when you can choose? Who defines what is best? Is the best the same for everyone? And to what extent does the idea that there are even better wines, an even better menu and even more spectacular views influence our experience of a meal? In this article, I aim to ask such questions in relation to selection processes in third-party reproduction and the idea of the 'healthy' baby: What selection processes are involved in third-party reproduction methods such as egg 'donation'[3]? How does this relate to the ways in which a 'good' future is imagined by employees in fertility clinics? And how is this future discursively legitimised?

Ellul (1954; 2012a [1977]; 2012b [1977]) and Illich (1995 [1975]) have analysed technology and medicine in the past as processes with anti-social effects. Recent debates on dis_ability[4] and ableism in turn have highlighted the social construction of dis_ability as deviance of a supposed 'normality' (2003; Dederich 2015; Ginsburg/Rapp 2017; Garland-Thomson 2005). Combining these analyses and drawing on an ethnography in fertility clinics in Spain, I aim to show the complex interplay between dominant visions and practices in the fertility clinic, their relation to technology as progress and their coming together in contemporary techniques of selection though which certain bodies are (re)produced, while others are discarded. I follow Alice Wong's definition of ableism as "a form of oppression that systematically devalues disabled people who are considered non-normative in the way they look, behave, move, think, or their way of being in the world" (2017). It is this systematic, yet often invisible ableist dimension

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[1] All names have been anonymised. All quotes have been translated from Spanish into English by myself.

[2] I use the term 'healthy' here in the sense of an emic description from within the clinic, which entails a vision that is conflated with ableist assumptions, often about illness and dis_ability as not clearly delimited categories. The use of quotation marks aims to highlight this definition of health as a specific social construct.

[3] I put the term 'donation' in quotation marks to question the altruistic aspect of this procedure. In Spain, donation is anonymous and altruistic, but donors are paid about €1000 as a compensation for donation, which is often more than a monthly wage for 'donors'.

[4] In using the term dis_ability, I acknowledge that 'disabled' is not a clear-cut category, but rather that between abled and disabled there is a continuum which can shift during the course of life (Goodley 2016). While I use 'disability' in describing the discourse of the clinics, where it is seen as a proxy of what should not be reproduced, I am using dis_ability when analysing my material.

which is at the heart of contemporary selection practices in fertility clinics that I aim to highlight in this article.

I proceed as following: In the first section, I will introduce the Spanish context and the different selection mechanisms in egg ‘donation’ arrangements, focusing on genetic selection and specifically on pre-conception genetic carrier screenings (CGCS). Secondly, I will focus on the visions and practices within the fertility clinic which are the ideological bases for these selection processes. Thirdly, I will show how these visions are stabilized by ideas of progress. In the conclusion, I contend that egg ‘donation’ arrangements as practiced today are to be considered not only as assisted, but rather as selective technologies and will make a call for the integration of dis_ability justice in third-party reproduction. The form of this article is more of an essay than a standardised academic article. It is a dynamic in-between of ethnographic material and theoretical reflections. The concept of ‘weaving’ proposed by Leigh Star (Bauchspies/Puig de la Bellacasa 2009) is a suitable metaphor for my approach: different types of knowledge (theoretical and empirical), but also different strands of theory (critical dis_ability studies, feminist approaches to bioeconomies, older critiques on technology) are woven together to illuminate selection practices and the dominant underlying visions in egg ‘donation’ arrangements in Spain. Rather than offering a comprehensive overview or advancing a singular, definitive argument, my aim is thus more experimental in nature. I seek to provide the reader with a series of theoretical and empirical insights that may serve as threads to inspire critical reflection on the topic of selection in third-party reproduction. The article is based on the ethnographic fieldwork for my PhD thesis in Valencia, Barcelona and Alicante from 2018 to 2019, which consisted of ten months of participant observation in a clinic and semi-structured interviews with ten egg ‘donors’, four egg recipients, and 38 in vitro fertilization (IVF) doctors, clinical staff and geneticists[5]. The egg ‘donors’ and recipients interviewed were not recruited through clinics and were interviewed outside the clinical context. As this research field is highly sensitive, ethical considerations were integral to my research design (Perler 2021). I obtained the participants’ consent both by building transparent, trusting relationships and by getting them to sign Informed Consent agreements. I coded the material in the Maxqda qualitative analysis program and analysed it inductively using Strauss and Corbin’s (1990) grounded theory.

2 The Spanish egg donation economy: Reprogenetics on the rise

Spain is one of Europe’s leading countries for cross-border reproductive care, especially for egg ‘donation’ (De Geyter et al. 2020; de Mouzon et al. 2010). In 2021, more than 12 000 ‘donated’ oocytes were extracted across 250 Spanish clinics, and around 11 000

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[5] This article relies on data and reflections that I developed for my PhD thesis and has also benefitted from discussions within the FemGeoBern collective. Earlier versions and parts of the text have been published in German in my book *Selektioniertes Leben: Eine feministische Perspektive auf die Eizellenspende* (Perler 2022).

embryos created from ‘donated’ oocytes were transferred to non-Spanish citizens (SEF 2021).

In addition to being Europe’s leader in egg ‘donation’, Spain also plays a prominent role in the field of reprogenetics. More than one-third of Europe’s preimplantation genetic procedures are conducted in Spain (Pavone/Arias 2012: 237). Of the total number of IVF cycles in Spain in 2021, around 45 percent were carried out in combination with PGT[6], with PGT-A accounting for the largest proportion, as it is often offered as an additional service for women over 35 (the main clientele of fertility clinics) and to increase the chances of success (SEF 2021; Pavone/Lafuente-Funes 2018: 130). While PGT is employed to select embryos, in this article I focus on another technology which aims at selecting donors genetically.

In addition to the medical and psychological screening that ‘donors’ have to undergo, a genetic screening called “Pre-Conception Genetic Carrier Screening” (PGCS) is conducted. PGCS is used to select donors by analysing genes associated with recessive hereditary conditions (for more information see Beaudet 2015; Henneman et al. 2016; Himes et al. 2017). Common conditions screened for today by PGCS include sickle cell anemia, hemophilia, cystic fibrosis, Tay-Sachs, Huntington, Turner syndrome, Klinefelter syndrome, and fragile X syndrome (WHO 2020). The range of variation that can be tested is steadily increasing, particularly after the commercialisation of universal carrier tests, so called Expanded Carrier Screenings (ECS) in 2010 (Beaudet 2015: 1). In 2020, the Spanish Society of Reproductive Medicine (SEF) suggested that about 50 variations should be tested in the selection process for egg ‘donors’ (Castilla et al. 2019). However, PGCS presents two major challenges, which I aim to address: it is grounded in ableist assumptions, and it reduces ‘donors’ to their genetic material. The underlying ableist assumption is already evident in the fact that screening for genetic variations is often presented as screening for diseases. For instance, Leon, a clinical manager from Barcelona, told me: “What we are doing is a ‘depistage’ of diseases that are serious. [...] There is a whole range of diseases that really nobody wants. This panel doesn’t stay the same, it is constantly being modified” (Leon, clinical manager, Barcelona, 2018).

But this terminology is misleading, as people with genetic variations “might be absolutely healthy, with no associated medical problems” (Shakespeare 1998: 669). Furthermore, to consider certain genetic predispositions as necessary to be acted upon brings the question of responsibility to the fore, as parents are expected to act and to take the ‘best’ decision for their offspring (this has been extensively discussed with relation to prenatal testing, see for example Lippman 1994; Rapp 2000). This debate has been accentuated with the issue of genetic predisposition, which brings with it the need to act even before conception on an unborn offspring, one already potentially at risk of being ill or dis_abled. In her studies on genetic counselling, Silja Samerski (2009, 2002) has shown how individualised risks are referred to specific bodies and how responsibility for the health of the offspring is imposed upon the patient with reference to a specific future. Through genetics the potential of the future becomes visible and thus calcula-

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[6] There are three different procedures: **PGT-A** (Preimplantation Genetic Testing for Aneuploidies, formerly PGS) looks for chromosomal variations such as Down, Klinefelter or Turner. **PGT-M** (Preimplantation Genetic Testing for Monogenetic Disorders, formerly PGD) looks for monogenetic disorders that run in the family. **PGT-SR** (Preimplantation Genetic Testing for Structural Rearrangements, formerly also PGD) is used to screen for hereditary chromosomal translocation disorders.

ble (Beck-Gernsheim 1995: 10). It is in this context that intended parents have to take decisions on an expanding set of technical possibilities of selection. As pointed out by critical dis_ability scholars, the conditions and "the broader social and cultural context in which decisions are taken" (Shakespeare 1998: 665) need to be analysed, especially in a society in which a good future is imagined as a future without dis_abilities (Kafer 2013: 29). In screening egg 'donors' for potential predispositions to future diseases or dis_abilities, clinics are thus endorsing an ableist idea of what is considered as worthy to reproduce.

The second problem with the PGCS is related to the "eggs-ploitation" (Pfeffer 2011) of egg 'donors'. Feminist research has revealed that egg 'donors' are often marginalized due to socio-economic inequality (Nahman 2013; Molas 2021; Mutlu 2022; Vlasenko 2015; Perler/Sánchez Pérez 2024). In the context of Spain, anthropological accounts have highlighted the problematic ways that clinics 'tame' 'donors' as a form of exercising control to keep them donating (Molas 2021; Molas/Perler 2020) and how 'donors' are taking risk in favour of a thriving bioeconomy (Molas/Whittaker 2023). Also, it has been shown that such risks are generally downplayed by private fertility clinics (Jacxsens et al. 2024; Molas/Whittaker 2021). What has not yet been discussed in-depth in this research strand is the role of PGCS with regard to egg 'donors' (with a recent exception, i.e. Hudson/Herbrand/Culley 2024).

While the desire for a 'healthy' baby, realized through selection, reproduces ableist ideas, with relation to egg 'donors' it has three major problematics: First, in Spain, it is compulsory for egg 'donors' who wish to donate to undergo screening, as the Spanish law states that the clinic must ensure that "donors do not suffer from genetic, hereditary or infectious diseases that could be transmitted to their offspring" (Ley 14/2006). So even if there is broad consent in society and bioethical debates that genetic testing should be voluntary, it is mandatory for egg 'donors' to undergo the screening. This follows an incident in 2016 in which Spain's largest clinic consortium, the Instituto Valenciano de Infertilidad (IVI), was sued by parents because their child – conceived with the help of an egg 'donor' – was born with haemophilia. As a result, IVI had to pay € 400 000 to the parents as compensation (Gallego 2016). As it has been recently stated by Hudson et al., 'donors' "have little – and perhaps ironically the least – autonomy in decision-making around ECS [PGCS]" (Hudson/Herbrand/Culley 2024: 5). Second, and as I explained in-depth elsewhere, the results of the tests are not always communicated to them, and if they are, they are not accompanied by genetic counselling, as directed by Spanish law (Perler 2022). Third, and building on the previous problematics, the PGCS reduces the 'donors' to their genetic material-serving as raw material to be selected for the transnational bioeconomy. In this context, 'donors' are not 'only' suppliers of oocytes, they also provide valuable epidemiological data to the genetic firms which are mandated to carry out the PGCS. 'Donors' are therefore important also to a new form of extractivism which Couldry and Mejias (2019) call 'data colonialism'. This refers to a phase of capitalism in which data of human life is getting extracted, digitized and appropriated.

To conclude, the Spanish egg 'donation' industry is very much linked to the reprogenetic sector, and egg 'donation' arrangements cannot be conceived without their relation to genetic selection processes. As I will now demonstrate, the growing reliance on genetic selection within the Spanish fertility industry is rooted in a broader set of dominant future-oriented visions within the clinical setting, which emphasize and celebrate technological advancements.

2.1 'Sex for fun, to the clinic for reproduction': Visions of the future

During the third month of my fieldwork, I was working in the administrative area of a fertility clinic. One day, the head doctor, José Luis, came out of a meeting with the international investors of the clinic and said:

> "So, if it's up to me, we do everything, son of a bitch. Ovo5, blastocyst stage, genetic matching (PGCS) and PGS (preimplantation genetic screening, now PGT-A) – PGS as the last step. So that I can say to the woman 'You want a healthy child? I'll do everything I can to make sure you have one'! Because let me tell you something: Women don't come here to get pregnant. No. Getting pregnant is just one step. But the truth is they come here because they want to take home a healthy child. And pregnancy is *not* necessarily leading to a healthy child. That's why, my dears, we're going to run through this for everyone from now on: Day 5, Blasto, genetic matching and the last step would be PGS." (José Luis, head doctor, Valencia, 2018)

The above quote, from my diary, is typical of central discourses that were circulating in the clinics in which I did my fieldwork. José Luis refers to the women seeking help not so much as 'patients', but as self-confident consumers, as in José Luis' words "they want to take home a healthy child". The idea of a 'healthy' child is also affectively charged. It points to a dominant "structure of feeling" (Williams 2015), an ensemble of desires and hopes for a 'healthy' baby, which forms the basis of the clinics' business. As such, the 'healthy' baby is the very "ultimate argument" (Siegl 2018) justifying the technological consequences, i.e. "Ovo5, blastocyst stage, genetic matching and PGS". According to Jacques Ellul, this is characteristic to what he calls "technique",[7] which is only socially and ethically evaluated in terms of its goal, but not in itself, which leads to such technology being propagated rather unreflectively (Ellul 2012a [1977]: 263). Ellul sees technology as carrying with it a promise of self-fulfilling prophecy. It would be too extensive to go into Ellul's conception of technology here, but what is important is that he understands technology broadly as a process for the organization of social life (Ellul 2012a [1977]: 35). In addition, technology is a specific milieu in the mediation between humans and their environment, and central to it is the idea of progress (2012a [1977]: 45). With his definition of tools, Illich offers a similar concept, in which he refers on the one hand to concrete utensils, but also to "productive systems that produce immaterial goods such as 'education', 'health', 'knowledge' or 'decisions'" (1998 [1975]: 41). According to Illich, these tools – if they are not placed under political supervision – develop their own autonomy (1998 [1975]: 129). The idea that tools or technologies develop unhindered because they are valued as progress in themselves is important to understand developments in fertility clinics. As I will now delineate, it is also due to specific imaginations of the future that this process of technologization gets

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[7] Ellul makes a distinction between technique and technology. According to him, while technique is much broader understood not only as a tool, but as a nearly autonomous process of the ultimate (technological) means for effective solution of all (social) problems, technology is already an interpretation of technique via the 'logos' (the reason and common sense). In the field of reproduction, however, the concept of technology has been established, which is why I will be using the term technology, even when I refer to Ellul.

further consolidated. During my research, I asked people how they imagine reproduction in the future. Juan, a geneticist working for fertility clinics, answered:

> "I think the concept of reproduction will change in the future. It was always thought that reproductive medicine would help infertile couples. But I think these clinics will become clinics for human reproduction, whether assisted or not. People go there who want to have children and who want to have more security. If you don't have fertility problems, you might need genetic matching, karyotype, genetic counselling or you might want to freeze your eggs for later." (Juan, geneticist, Valencia, 2018)

This statement is paradigmatic of the visions of the future circulating in the clinics I visited. Two elements are central to this. First: In the future, reproductive medicine will be completely normalised. One doctor says: "Sex for fun, to the clinic for reproduction" (Ricardo, doctor, Valencia, 2018). Secondly, reproductive medicine is no longer primarily used as a means to overcome infertility, but is understood as 'safer', minimizing the risks of disease and dis_ability. What 'safe' entails here (namely a non-dis_abled, not-ill offspring) is ableist per se. Critical dis_ability approaches have investigated how certain conditions arise as 'abnormal' and thus construct an ableist society as the norm from which dis_abled people diverge (Dederich 2015: 19). While the medical model of dis_ability sees impairments in body functions as medical phenomena, the social model of dis_ability to which these scholars refer focuses on the social constructs imposed on the impairments (Haegele/Hodge 2016). Using the example of prenatal testing, Shelley Tremain demands that a normalising discourse which takes "the 'impaired fetus' as a natural kind" (Tremain 2006: 49) requires a critical stance and should be replaced by a cautious description of how this very idea of impairment is produced in the first place by certain discourses and practices. Recently, Kandlbinder has argued with regard to the bioethics of assisted reproduction that the concept of "life not worth living" – which is often employed to assess the morality of a certain technology – is conflated with ableist assumptions (Kandlbinder 2024). From a critical dis_ability perspective, this enthusiasm for a 'safer' reproduction in the future is problematic. Following the arguments of these scholars, I argue that the wish to have a 'healthy' baby in the clinical setting is entangled with the manifold imaginaries, practices and technologies that are constructing 'normality' (and the deviance from it) in the first place. In the next section, I will describe how this normalisation of producing a 'healthy' baby is stabilised by unquestioned notions of progress in clinics.

3 It will be better in the future: Normalisation through imaginaries of progress

In the discourses of my interlocutors, the fertility clinic of the future is described as better, more comprehensive and more far-reaching than today's. The following quote from a clinic manager is typical of the visions within the fertility clinics I visited:

> "A hundred years ago, when they did this exercise of thinking about what the world would look like in the future, it was probably spaceships or flying with mechanical devices. Those were probably the things that were imagined. Today the big advances are in further networking, genetics and biology. So, they are actually two different directions. Today, going to Mars or into space is much less interesting, it's more in the direction of being able to manipulate human beings in their being. But people in a hundred

> years' time will find these debates we are experiencing today very primitive. Like when we see the first drawings of spaceships going to the moon. Something like that. And reproductive medicine, I think, is one of the things that will have a significant impact on society in the future." (Hector, clinic manager, Valencia, 2019)

This attitude towards technology as progress is visible also in the following answer from a nurse to the question of what reproductive medicine will look like in ten years' time:

> "Reproductive medicine in ten years? Phew, just looking at how fast it's gone so far, I don't know. Everything will certainly be much more precise, hereditary diseases will be a big issue, the selection of the best embryos, the dosage of drugs will be much better adapted. We will have much more sophisticated techniques. The big change will be in genetics, that's for sure." (Sara, nurse, Valencia, 2018)

These quotes indicate that the future in the clinic will be linked to what is seen as scientific progress and what is linked to genetics. The fact that the future is drawn as inevitably better than the present has been described by Ellul as technology's "tendency to totalization", which through the inherent aspect of progress, produces a very specific vision of the future. He argues:

> "When a technique disappears [...] it is because it is replaced by another of the same order, but superior [...] What gives the most striking image, moreover, is the ever-renewed assertion that in ten years, in twenty years, the technicist system will be 'complete' [...] on the one hand it disintegrates and gradually tends to eliminate everything that is not technicisable [...] and it tends to reconstitute a whole of this society from the technicist totalization." (Ellul 2012a [1977]: 207 ff.)

Indeed, a central feature of the employees' visions of the future is their affinity with technology and progress. For instance, Elena, the clinical psychologist, told me in an interview about her opinion on the future in reproductive medicine:

> "The advances in science and technology, well, they offer more and more possibilities, don't they? Processes are becoming more and more refined, treatments shorter, safer, more efficient in general. I think so, science is finally evolving and progressing, and in the process, most of it is probably getting better, isn't it?" (Elena, clinical psychologist, Valencia, 2018)

Clinical personnel describe these new possibilities as simply new options. But this idea of technological progress is also embedded in the contemporary capitalist self-understanding "that construes life as a project, framed in terms of the values of autonomy, self-actualisation, prudence, responsibility, and choice" (Rose 2006: 125). In an Ellulian understanding, this new freedom can also be ascribed a compulsory character, because "man does what technology allows him to do" (2012a [1977]: 153). In this understanding, technology is an autonomous system that neither follows moral principles nor can be morally evaluated (2012a [1977]: 152). As a result, it becomes unstoppable "since it is outside good and evil" (2012a [1977]: 154). In this process, technology and science legitimise each other: one researches what is technically possible and thus technology becomes the basis of science, which ultimately leads to the creation of a new technophile ethics, which is an ethics that embrace technology as per se leading to better conditions. A technophile ethics was omnipresent among the clinical staff – and it was very much related to genetic technologies. For example, an embryologist comments on the necessity of genetic testing: "So if I give an egg with a genetic mutation to a patient and

I put it together with a sperm with the same mutation and it results in a sick child, if I can prevent that, then it's only ethical to do that" (Verónica, embryologist, Valencia, 2018).

This aspect of technophile ethics is also reflected in a statement by a geneticist on the general role of genetics in the future:

> "Of course, in the future, genetic counselling must play a central role in our lives. Both in reproductive medicine, but also in hospitals, in schools. Just like a hundred years ago with the advent of social rights. People didn't know what a wage was, and today everyone knows – because knowledge spread, because it was explained. And today it's the same. You have to know what a genetic disease is and how it is transmitted. If you have a reproductive project before you have children, you need to know what can be known. Then you can decide what you are going to do. Of course, you may not be completely free, as you said earlier, for social reasons […] But knowledge is freedom in a strict interpretation. If you don't know anything, then you can't decide anything. Not knowing is slavery." (Juan, geneticist, Valencia, 2018)

Juan's statement refers to this technophile ethics, which is created via technology, in this case through genetic techniques such as PGT and PGCS. In the process, not knowing becomes the antithesis of freedom, i.e. "slavery". The use of technology is thus conceptualized as a new freedom and at the same time as a new normality. Another geneticist commented that PGCS should become as "normalised as ultrasound for pregnant women" (Manuel, geneticist, Valencia, 2018). Critical dis_ability scholars question this new freedom:

> "In previous generations, once safe and reliable contraception was available, prospective parents could only control the number and timing of their children. Now they can increasingly influence the nature of their children, a move from quantity to quality control. Sometimes, ignorance is bliss." (Shakespeare 2011: 40)

In sharp contrast, in the discourse of clinicians and geneticists, technology is predominantly understood as progress, and broad access to these specific technologies is demanded.

4 Conclusion

A year after completing my fieldwork, I returned to the clinic to discuss my preliminary findings. When I told Hector, the manager, that I planned to work mainly on the topic of technology, genetics and the future in fertility clinics, he said:

> "Sure, this is very important, the basic concept of reproduction is changing. I think there is a group in the US that is talking quite openly about the need to decouple sexuality and reproduction. And even if you don't have fertility problems, you can go to these clinics. Reproduction then takes place in a safe environment in the laboratory. Of course, such a statement raises a lot of questions in our society. [...] It is very likely that in a hundred years, reproduction as a concept will be something completely different than it has been since the beginning of human history. That it is no longer something 'natural'. That it will be a clinical process instead." (Hector, clinic manager, Valencia, 2019)

Hector's statement summarises the visions of the future that I have heard in different variations from clinical staff. The common thread in these visions is the assumption that in the future the fertility clinic will be separated from the idea of infertility: "A normal reproduction, only safer" (Juan, geneticist, Valencia, 2018). The technology- and progress-savvy perspectives of the clinic staff suggest that the focus on health has become a central part of this system. For as Ellul wrote more than 50 years ago: "To be situated in this technical universe, and at the same time not to discern the system, is the best condition to be integrated into it, to be obviously part of it, without even realising it" (Ellul 2012a [1977]: 320). As I have shown in this article, referring to the work of critical dis_ability scholars, this process is also clearly in the "service of compulsory able-bodiedness and able-mindedness" (Kafer 2013: 27). It seems clear that dis_abled bodies will not be reproduced in the 'safe' future that is envisioned in the clinical realm. With the expanding possibilities to test on more genetic variations, the limits of what is still reproducible and what should be prevented remains rather vague. Furthermore, if we consider the example of PGCS in relation to egg 'donors', intended parents are deciding on a possible future simply by selecting certain 'donors', which means that this very process of selection is also outsourced to a third party and thus even more disembodied, which raises further ethical dilemmas. Michael Berubé developed on that when he says:

> "[E]ven in the not – too distant – future, we might feel a profound moral repugnance at the idea of terminating a pregnancy simply on the basis of the finding that the fetus has a genetic propensity for obesity, myopia, or premature baldness. But if we could select against these features at fertilization, would we do so, and what moral grounds would we offer for refusing to do so and preventing others, by law, from doing so?" (2013: 93)

The widespread use of PGCS shows how assisted and selective reproduction are intermingled in the practice of egg 'donation'. The use of this selection mode is also an indication of the increasing geneticisation in the standardisation of bodies that occurs in many fertility clinics. Wahlberg and Gammeltoft (2018: 5) make a distinction between assisted reproductive technology (ART) and selective reproductive technology (SRT) because their goals are different: "If 'nature-assisted' is a fitting caption for ARTs, then SRTs might be summarised as 'nature-directed'." This separation of ARTs and SRTs becomes obsolete in the case of Spanish fertility clinics because in the imagined reproductive clinic of the future – and thus in many ways already in today's Spanish reproductive industry – ARTs and SRTs cannot be separated. When the 'healthy' child is the primary goal of reproductive technologies, when fertility clinics no longer address infertile people but, above all, want to ensure 'safer' reproduction and do this through the widespread use of (genetic) selection techniques, these two technologies merge. The future of reproductive medicine is not the treatment of infertility but the production of 'healthy' life and therefore 'nature-directed'.

As social scientists, we need to be aware of the ableist assumptions that underpin these processes and shed light on what this means for the different stakeholders involved in the 'making of future lives'. We should also critically engage with the risk that such (genetic) selection processes could "result […] in the further subordination of people with disabilities (and other marginalized communities) because it fails to acknowledge the ways in which capitalism, racism, and ableism disable and oppress people" (Mukherjee/Shirinian 2022: 13). It would be essential to integrate a dis_ability justice perspective in the field of third-party reproduction. Drawing on feminist and critical dis_ability studies, we should also start to imagine reproductive futures otherwise, embracing the idea of vulnerability as a human condition *sine qua non*. We would be well-advised to think of the present and the future as already multiple and contingent, and as such to make possible a variety of future visions beyond the hegemonic cultural norm (Salazar et al. 2017: 15). An example would be to listen to those who are living with dis_abilities (see, for example Ginsburg/Rapp 2017). The omnipresence of 'health' in fertility clinics is problematic because it praises independence and autonomy at the expense of vulnerability and dependency. In contrast, we could embrace vulnerability as something valuable. Eva Kittay, for instance, argues in her book *Learning from My Daughter: The Value and Care of Disabled Minds* (2019) for a recognition of relationality and dependency among people. She takes dis_ability as a starting point for what she considers should be the leading social-guiding principle: to care for each other. Kittay also calls for an inclusive idea of justice with dependency at its core. This would allow to "look at the fact of human dependency anew. We see it not as an impediment to living well, but as a source of value: a source of connection; an occasion for developing our capacities for thought, empathy, sensitivity, trust, ingenuity, and creativity; in short, as providing for us the conditions of our distinctive human freedom and dignity" (Kittay 2013: 310). If dependence, vulnerability and care were recognized as fundamental human dimensions, reproduction could be thought of in a different manner, not just as a technical issue but as a social endeavour, which connects us as vulnerable human beings in our respective situatedness.

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