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## ORIGINAL ARTICLE


# Doing and undoing nation through ART: a Franco–American comparison

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**Abstract** This article explores a Franco–American comparison of assisted reproductive technology (ART), specifically as it relates to sex selection and cross-border reproduction. As a basis for comparison, the nation can materialize in the form of state structure just as much as in cultural–economic assemblages or ideologies that breach geopolitical boundaries. By juxtaposing many contrasts between the French and US contexts – departure versus destination country, highly regulated versus deregulated governance, medical versus social applications, and access (or lack thereof) via public versus private health insurance sectors – it may be difficult to imagine how these extremes occupy a common continuum of globalized market channels. I suggest that invisible or semi-visible reproductive practices along with ART governance provide an avenue to stake out or protect the 'French' way of being and doing ART just as much as they make the 'American' way simultaneously elusive and easy to appropriate. Ultimately, both the French and American approaches to ART collude in the institutionalization of globalized markets. Through the case of cross-border (and (sex) selective ART, it is possible to see how both the French and the Americans are involved in the undoing and doing of nation via ART as global assemblage. 

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**KEYWORDS:** ART in comparative context, cross-border reproduction, sex selection

What might we learn from a Franco–American comparison of assisted reproductive technology (ART), specifically as it relates to sex selection and cross-border reproduction? France outlaws sex selection. It is 'as taboo as cloning and as rejected off the bat as [s]urrogacy' – according to one participant of a Franco–American Workshop on interpreting

ART in both countries from a comparative perspective held in New York City (2018) and Paris (2019). In the USA, sex-selective ART is not only not illegal (although several states have recently prohibited sex-selective abortion), it is also not unethical. France is a departure country in cross-border reproductive circuits, while the USA is a destination country. The golden rule that seems to guide governance in

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France is to limit all ART to medical indications, whereas in the USA, non-medical (i.e. 'social') uses proliferate unchecked. Through its national health insurance, France covers the costs of ART for those who are eligible, but for all the purported autonomy and choice that US patients are granted in relation to ART, the procedures remain largely inaccessible as patients must incur much, if not all, of the expense. If there is a story to tell here, it appears to be a short story of contrasts.

However, if we explore the juxtaposition further, might it give us a better understanding of the doing and undoing of nation through ART? Might invisible or semi-visible reproductive practices along with ART governance provide an avenue to stake out or protect the 'French' way of being and doing ART, just as much as they make the 'American' way simultaneously elusive and easy to appropriate? Instructive to the workshop exercise of comparing ART practices across two nation states is a denaturalized and deterritorialized idea of nation. Following transnational feminist and globalization theorists, this usage draws attention to the ways that state action or inaction have consequences for the actualization of its nation both inside and outside state borders in ways that are integral to building a global capitalist economy. Ultimately, both the French and US approaches to ART collude in the institutionalization of globalized markets. The following analysis incorporates and reframes my own empirical work in the USA within the context of insights gained at the comparative workshop and through subsequent literature review on the French case. It is therefore limited by dissimilar use of methods in each context.

### Cross-border and (sex) selective ART – France

While limited literature exists in English on French cross-border ART, the findings must now be contextualized against a current state of flux in the legal situation of ART in France. As I write this, news media announces the progression and reaction including protest of a new bioethics law in France proposed by Emmanuel Macron's government that would extend eligibility for in-vitro fertilization (IVF) to single women and lesbian couples, among other changes. LGBTQ groups began lobbying for this law after France legalized same-sex marriage in 2013 under the administration of the former French president, François Hollande. Hollande, who initially backed ART access for gay couples, eventually pulled back his support after the 2013 same-sex marriage law elicited massive protest and backlash. Today's news commentators anticipate that the country's legislators are now ready to pass the proposed law in spite of ongoing but considerably weaker opposition compared with 6 years ago (Agnew, 2019; McAuley, 2019).

France's approach to ART must also be contextualized against its historical penchant for pronatalism in contrast to some European counterparts, particularly Britain (Latham, 1998; Olszynko-Gryn and Rusterholz, 2019). The French bioethics law, first framed in 1994, enshrined what bioethics scholars call the 'French conservative approach', which, among other things, limited ART access to heterosexual, cohabitating couples who are medically infertile; prohibited surrogacy; and prescribed strict anonymity in

gamete donation. Two minor revisions in the law in 2004 and 2011 did not change the overall 'conservative' approach (Fournier and Spranzi, 2013: 44). Should Macron's proposed bill become law, it would represent a sea change in the ethos of French bioethics, which, to date, has been largely motivated by strict governance of ART to allow 'medical' rather than what are viewed as 'social' indications. This precluded the use of ART by single women, same-sex couples, and women and men above the prescribed age categories (43 years for women and 60 years for men). In spite of these restrictions, for those who are eligible, the French state is comparatively generous in its provision of ART, providing national health coverage for up to six insemination and four IVF cycles (Pérez Hernández, 2019; Gomez and de La Rochebrochard, 2013: 3108).

Macron's draft law, if enacted, may put a dam on several streams of French reproductive travel and weaken arguments that presume that the domestic impact of cross-border reproduction necessarily stymies the potential for change in the 'French' way of handling ART. Signifying a major shift in the French position on ART access, the proposed law might indicate the start of a further unravelling of until-now strictly enforced divisions between the 'medical' and 'social' indications in ART practices.

Scholarship on cross-border ART practices in Europe identifies France as one of the four top departure sites behind Italy, Germany and the Netherlands (Shenfield et al., 2010: 1361). Cross-border reproduction in Europe, for the most part, stays within Europe (Präg and Mills, 2017: 14) and the movements tracked by French patients are largely to Belgium, Spain or Greece. Single women and lesbian couples tend to head for Belgium to access sperm donation, and heterosexual couples seek oocyte donation in Spain or Greece, with Greece providing the lower-cost alternative for low-income French travellers (Gomez and de La Rochebrochard, 2013: 3103).

As '73% of French CBRC [cross-border reproductive care] patients in Belgium used sperm donation, and 80% of CBRC patients using sperm donation in Belgium were French' (Gomez and de La Rochebrochard, 2013: 3108), scholars have focused on this particular stream of travellers whose motivations, as primarily single women and lesbian couples, clearly lie in evading the law. However, this group of reproductive travellers is not entirely invisible, especially when pregnancies are successful. Upon their return to France, the national health system takes charge of the costs and care of any resulting pregnancy, as it would for every French citizen.

Van Hoof et al. (2015) undertook a qualitative study of French women travelling to Belgium for treatment with donor sperm, and documented the numerous challenges faced by these women. These include finding local clinics to monitor their cycles, and difficulty taking time off work given that they are not entitled to a leave of absence on medical grounds. Their research underlines the extent to which cross-border reproduction in the case of ART is operationalized via transactions across borders between clinics on either side. The authors highlight the importance of such cooperation for the cross-border system to work, and detail the types of assistance that physicians in departure countries could provide:

The local physician can be a source of information and support before, during and after treatment, he [sic] can perform part of the treatment (cycle monitoring and – drug prescription) which reduces the number of times patients need to travel to the foreign clinic and he [sic] can even prescribe sick leave or game the system to obtain partial reimbursement for the law evading treatment cycle (Van Hoof et al., 2015: 396).

The informants in the study by Van Hoof et al. (2015) described a range of actual experiences with their local physicians in France, including refusal of care, but a significant number (nine of 13) found ‘a supportive physician who was willing to game the system for them’ (Van Hoof et al., 2015: 395).

Governed not only with legislation but also through professional guidelines, French local physicians are provided with a certain amount of flexibility as they are not only obligated to follow the law but also to uphold best practice. The ‘good practice’ guide of the European Society for Human Reproduction and Embryology (ESHRE) explicitly states, ‘Collaboration between the home practitioner and the receiving center offers the best chance of optimal care for the cross border patient’ (Shenfield et al., 2010: 1626). This combination of regulation via professional guidelines and the law might resolve any ethical tension arising for the home practitioner engaged in assisting ‘a law evading’ cycle.

In spite of this recommended collaborative model, scholarship on cross-border ART has almost exclusively taken place by studying the providers and patients received at destination clinics. Very little is known about cross-border reproductive practices from the perspective of departure site physicians. The research of Malmanche, a doctoral student at the School of Advanced Studies in Social Sciences in Paris, provides a rare corrective to this situation, as she interviewed both fertility specialists in Belgium and obstetricians in France on the receiving end of pregnancies conceived abroad from treatments involving gestational surrogacy, egg donation, and sperm donation to lesbian couples. Malmanche (2019) describes a context in which the transgressive potential of minority reproductive practices to prompt a change in societal views and illuminate unrecognized majority norms cannot be realized when they are simply outsourced abroad. Präg and Mills present a similar argument suggesting ‘the value of legal restrictions on ART is largely symbolic’ given the ease with which Europeans can cross borders to access care. Opportunities to legally access treatment abroad disincentivize ‘patient groups and other national stakeholders’ from seeking to influence the policy-making process at home, thereby protecting the status quo (Präg and Mills, 2017: 304). While bioethics scholar Pennings more positively describes the impact of reproductive travel within departure states as a potential ‘safety valve that reduces moral conflict and expresses minimal recognition of others [i.e. the minority’s] moral autonomy’ (Pennings, 2004: 2689), Malmanche (2019) asserts a different reality. She observes how the system allows the state to reinforce a logic of erasure of donor-conceived children, for a large majority of them are not accounted for by the Agence de la Biomédecine, France’s primary regulatory authority of ART practice.

In addition, the historical model of anonymity and secrecy that emerged in France to maintain the pretence of biogenetic relatedness for infertile heterosexual couples who utilize donor gametes remained unchallenged until recent debate on the new bioethics law. Malmanche’s empirical work uncovers how a midwife and the head of a maternity ward take meticulous measures to maintain such secrecy, such as by removing accompanying relatives or friends from a clinical encounter in which information on the patient’s use of a donor conception process must be addressed (Malmanche, 2019). The new bioethics law, which would allow donor-conceived children access to the identity of their donor(s) at the age of 18 years, may open the door to greater transparency of donor-conception processes and disclosure to children of their donor-conceived status. However, in the current context, removal of strict donor anonymity appears to be motivated, in part, by a conservative standpoint seeking to preserve genetic paternity for children of single women or lesbian couples, who by the very same law stand to gain ART access in France (Donadio, 2019).

In line with the state’s until-now strict maintenance of medically indicated fertility care, France’s Agence de la Biomédecine has also restricted egg freezing to cases where ill patients, such as patients with cancer, seek to avoid the gamete-damaging impacts of their treatment. Limited exceptions were made for those egg freezers willing to donate up to half of their retrieval count or a minimum of five eggs for donation. Social egg freezers, who do not wish to donate or do not qualify for donation, have had to engage in ‘law evading’ cycles abroad to retrieve and bank their eggs (Pérez Hernández, 2019). In her study of French social egg freezers, Perez Hernandez documents how the strict institutionalized divisions between the three categories of medical, social and shared-donation egg freezing are routinely breached in user reflections on their practice. The study includes women without partners, who, in some cases, had experienced recent relationship break ups. The new bioethics law (passed in the French national assembly on 27 September 2019) brings the country in alignment with ESHRE’s professional guidelines on this practice, which have articulated an ethically permissive stance towards social egg freezing since 2012 (ESHRE Task Force on Ethics and Law, 2012).

The ‘intense public debate and heated discussion’ (Fournier and Spranzi, 2013: 44) taking place in the wake of each proposed revision to the law will finally, after 25 years, it appears, yield substantial shifts in access to ART. However, some of the law’s least controversial aspects, such as the prohibition of surrogacy, remain, and apparently there is no discussion whatsoever when it comes to the prohibition on sex selection. Indeed, while France appears ready to widen its ambit of ethically permissible ART practice, it will likely fortify the remaining divide to other practices that are not up for debate.

As far as sex selection is concerned, there is harmony between France’s laws and its commitment to international treaties and recommendations. France signed and ratified the European Convention on Human Rights and Biomedicine (‘Oviedo Convention’) in 1997. Article 14 of the treaty states, ‘Techniques of medically assisted reproduction shall not be allowed for the purpose of choosing a future child’s

sex, except where serious hereditary sex-related disease is to be avoided' (Council of Europe, 1997). Moreover, France's laws reflect international directives on preimplantation genetic diagnosis (PGD) as articulated in a report by the International Bioethics Committee of UNESCO, which states, 'Destruction of embryos for non-medical reasons or termination of pregnancies because of a specific gender are not "counterbalanced" by avoiding later suffering by a severe disease. Sex selection by PGD or PD is therefore considered to be unethical' (UNESCO, 2003). Under the French Public Health Code, PGD can only be authorized by the Agence de la Biomédecine in circumstances where the users have 'a high probability to give birth to a child suffering from a genetic disease of particular gravity recognized as incurable at the time of diagnosis' (translation in Duguet and Boyer-Beviere, 2017: 166). While restrictive, this position could be viewed as relatively more liberal than other countries in Europe, such as Ireland, Italy, Switzerland, Luxembourg and Germany, which banned PGD altogether until recently (Duguet and Boyer-Beviere, 2017: 169). In line with its general stance toward ART to date, France's governance on PGD follows a strict medical justification for use, and there does not appear to be any movement for change on these regulations.

France's law cementing ART as a means to treat the medical indication of infertility, rather than social needs, is now 25 years old; it seems clear that subsequent social, political, cultural and economic shifts towards neoliberalization across Europe will inevitably impact the way in which ART is practised, if not also governed, there. Through ethnographic work in the ART department of a French public hospital, Arkin describes a context in which France is 'betwixt and between' conventions that centre the autonomy and choice of patients indicative of a neoliberal ethos and more traditional paternalistic medical care (Arkin, 2019). Moreover, France is certainly not immune to what Faircloth and Görtin describe as shifts in 'parenting culture' that increasingly impact the preconception period (Faircloth and Görtin, 2018: 990). Faircloth and Görtin, who argue for connecting sociological inquiry on parenting culture and ART, describe a Euro-American context (increasingly globalized) of low fertility, anxious reproduction and 'intensive parenting, with the optimally developed child at the centre' (Faircloth and Görtin, 2018: 990). Drawing on parenting culture studies, the authors describe new responsibilities of parents that go far beyond 'ensuring the transition to adulthood', to optimizing their offsprings' 'physical, social, emotional, and cognitive' development (Faircloth and Görtin, 2018: 985–986). They point to how this culture intertwines with ART practices, claiming, for example, that 'ARTs extend parenting behavior temporally backwards', and that 'the same concerns and rules that govern parenting "culture" are also "generating" a "culture" of ART engagement' (Faircloth and Görtin, 2018: 990). The temporal dimension of parenting culture also extends far forward into the young adulthood of the 'child' as the recent extreme case of parents involved in a college admissions scandal in the USA attests. The culture of ART engagement impacted by these trends likely manifests through the increased routinization of selective reproductive technology practices, which Wahlberg and Gammeltoft describe as 'ubiquitous' in the 21st century (Wahlberg and Gammeltoft, 2018).

Although the French engage in visible practices of selective reproduction, such as gamete donation that takes place both domestically and across its national border, it is currently unknown whether the French would be interested in expanded uses of PGD including sex selection. While not among the top departure sites for sex-selective ART practices into the USA, the two clinic directors I interviewed in my own research on cross-border sex selection listed French citizens among their international clients (Bhatia, 2018). Suspecting that French patients seeking sex selection may travel to Northern Cyprus, I reached out to two clinics there offering 'gender selection'. A manager at one clinic estimated that they receive two to three French patients per month. Offering anecdotal evidence that these patients cannot find French physicians to help begin their cycles at home, the manager recounted how their French patients usually complete their full cycle – taking place over a duration of approximately 18 days from start to finish – at the centre in Cyprus (telephone communication, 13 September 2019). A coordinator of a second IVF clinic in Northern Cyprus could also easily confirm that they receive patients from France, but could not estimate the number. In the case of this particular clinic, their French patients do begin their cycles at home in most cases. The clinic simply sends a script to the French gynaecologist for the medications needed to begin the cycle. The local doctors in France cooperate and convert it to their local pharmacy. The coordinator suspected that these patients do not disclose to their French physicians that their cycles involve sex selection (telephone communication, 19 September 2019).

### Cross-border and (sex) selective ART – USA

In contrast to France, the USA is recognized as a destination site rather than a departure site in cross-border ART. Jacobson notes that international clients represent a small but growing segment of ART users who travel to the USA in spite of the high procedural expenses they must bear. Due to a large commercialized private sector ART market, a permissive regulatory environment, and a reputation of skilled, quality care available to anyone with the ability to pay, international clients come to the USA, and US clinics cater and market to them (Jacobson, 2019). Drawing on her own extensive research on surrogacy, Jacobson describes 'perks' offered by the US market. Rather than serving as sites for basic market transactions, some clinics promote unique ART experiences, such as fostering relationship building between gestational surrogates and intending parents (Jacobson, 2019). The ethnographic work of Martin focuses on international travel to the USA to access selective reproductive technology, such as egg donation, where providers market US 'multiculturalism' as an asset and market advantage over other egg donation hubs because it increases the chances that a phenotypic match between donors and clients can be made (Martin, 2014: 441).

In the case of sex-selective ART, the USA drew an early competitive advantage within the global market because the US fertility profession invested in developing and legitimizing the practice through material, discursive and institutional means just as many other countries condemned or outlawed sex selection at the end of the 20th century.



Unlike France's strict limitation of PGD use to medical indications, PGD fell outside the purview of various US federal agencies of regulatory control. Nor did the US Food and Drug Administration (FDA) require premarket approval (as they did with MicroSort sperm sorting) that would classify PGD as experimental and forestall commercialization pursuant to a determination on its safety and efficacy (Baruch, 2007; Baruch et al., 2008; Schuppner, 2010). Although non-binding, US professional organizations, such as the American Society for Reproductive Medicine (ASRM), stepped in to ensure ART clinic control over the decision of whether and how to apply PGD as it fell outside the locus of government or clinic independent regulatory mechanisms. The Ethics Committee of ASRM, in particular, took the lead in the formative stages of development of sex-selective ART, releasing a statement on PGD in 1999 and another in 2001 on sperm sorting. As I argue in my book, these statements, even when they formally discouraged sex selection for non-medical reasons, did not construct the practice as intrinsically unethical (Bhatia, 2018). Rather, they interpret sex-selective ART as a preferred set of techniques to those that involve abortion, and they authorized individual clinics to interpret on a case-by-case basis, and without government interference, ethical sex-selection practice. Years later, in 2015, the Ethics Committee of ASRM released a new statement that acknowledges 'reasoned differences of opinion about the permissibility of these practices' (Ethics Committee of the American Society of Reproductive Medicine, 2015: 1418). Documenting arguments both for and against sex selection via ART, the statement does not provide a consensus view, instead urging clinics to come up with their own policies. Importantly, ASRM has retracted its previous directive for clinics either to discourage or not encourage sex-selective PGD for non-medical reasons depending on the scenario in which it is sought (apart from or alongside other medical applications of the technology). Thus, sex-selective ART in the USA is not only 'not illegal', but is also viewed by the fertility profession as ethically permissible.

The prime motivating factor for cross-border sex selection to the USA is circumvention of legal bans on the practice in the country of origin of those clients who seek it, although unavailability of technology and expertise contribute to this trend. The discrepancy between an overwhelming absence of regulation in places such as the USA, together with prohibitions of non-medical sex selection in China and India since 1994, the UK since 1995, Europe since 1997, and Canada and Australia since 2004, prompt travel abroad to circumvent the law. As a major destination site for cross-border sex selection, the USA has consistently drawn many international patients who desire sex-specific children and can pay for their cycles out of pocket.

When I started researching sex-selective ART in the USA, one of my earliest surprise findings was the extent to which clients were coming across borders to the USA. Much of my research took place at two private clinics in California that had heavily marketed the technology and were often featured in news and popular media on the topic, even when the professional ethics authority still discouraged the practice. One of my first interviews was with a nurse. We spoke for a long time on the telephone after work hours, while she was still in the clinic, and she was the first to explain to me

the intricate work involved in moving patients through transnational cycling. This included interacting with physicians in departure locations where the cycles would begin without disclosing that it involved sex selection. I eventually visited both of those clinics, shadowed their directors and interviewed several of their staff members. I learned quickly that international clients represent a substantial portion – at least half according to the estimations by their clinic directors – of those seeking sex-selective ART in the USA (Bhatia, 2018).

These two US-based clinic directors revealed a complex picture in multiple interviews and conversations in which diasporic communities and transnational commerce figure prominently. Their accounts complicated the West/non-West binary taken for granted in depictions of sex-selective ART in mass news and popular media, which rarely, if ever, visually represent users from immigrant and minority communities within Western contexts, and wealthy patients travelling from regions of the world such as Africa, Central Asia, Eastern Europe, and South and East Asia.

Beginning in US-based clinics, my own empirical route to the study of US sex-selective practices via ART extended into another globally significant fertility hub: Mexico. The fact that US-American, sex-selective ART exists outside the USA through the establishment of offshore laboratories and clinics strikes at the complexity of centring nation in comparative ART. In a study of Mexico's history of assisted reproduction, science and technology studies scholar, González-Santos describes epistemic and institutional shifts that formed the basis for the expansion of the assisted reproduction industry in Mexico. These included the training of many Mexican reproductive endocrinologists in the USA, and direct assistance by US-based specialists in the establishment of reproductive biology laboratories and private assisted reproduction clinics. According to González-Santos, the rapid growth of ART clinics across Mexico since the late 20th century is characterized by outsourcing of multinational corporations and the building of satellite extensions of networked clinics (González-Santos, 2016: 122–123). In addition to the actual structural ties that clinics operating in Mexico have with US-based clinics, Schurr, who applies a critical mobilities approach to the study of Mexico's fertility industry, documents heavily used representational strategies in marketing fertility sites in Mexico as equivalent to the USA. In addition to comparable fertility expertise, success rates and technologies, one medical agent interviewed by Schurr touted that Cancún offers 'like any other Southern American City', a Wal-Mart and Starbucks on every corner (Schurr, 2019: 111). For me, the 'Americanness' of the site was made apparent when, after explaining my plan to conduct research in English at sites owned and operated by US clinics in Mexico to the institutional review board at my home institution, I was not required to submit additional documentation normally expected in international research to ensure compliance with the regulatory and cultural norms of the host country.

In the summer of 2015, I visited Guadalajara, Mexico, coordinating my trip with a team of US-based providers who travel to their satellite location there approximately eight times a year. I observed clinical practice including egg retrievals and embryo transfers, and conducted inter-

views with the team, which included the clinic director and two embryologists. I also visited the first MicroSort laboratory for sperm sorting established outside the USA in 2009, which is owned by the Genetics and IVF Institute (GIVF) based in Fairfax, VA in the USA. Therefore, the USA also serves as a departure country for providers and some users of sex-selective ART seeking lower costs, or, in the case of MicroSort, legal circumvention since 2010 when the US FDA prohibited 'family balancing' applications in the GIVF-sponsored MicroSort clinical trial (Bhatia, 2018). Family balancing was coined by GIVF to refer to a non-medical indication of use for selecting the sex of the offspring.

According to the specialists I interviewed at the US-American clinic and MicroSort laboratory in Mexico, sex-selective PGD users come primarily from abroad, most often from the USA, then Europe (especially Spain), then Canada and Australia. One US-based clinic director, who regularly travels to his satellite location in Mexico, said that once he began to advertise reduced-cost IVF services, his clients coming from the USA to Mexico increased three-fold. Although PGD costs are the same, IVF prices decrease by nearly \$10,000 due to reduced ancillary costs such as use of the hospital in Mexico, which he claimed actually had better equipment than in a hospital in a main city of his operations in a US western state. Sometimes Mexico provides a convenient US satellite location for those reproductive travellers who have difficulties getting visas to the USA, such as Chinese nationals. Some travel for MicroSort intrauterine insemination with sorted sperm because they do not wish to select or produce an excess of embryos. Others have tried PGD/IVF but failed to produce embryos of the desired sex; they hope that a combination of MicroSort with PGD/IVF will increase that possibility. In many cases, men (most often from the USA, Nigeria, or Australia) travel alone to the MicroSort laboratory to provide fresh sperm samples that are sorted and shipped frozen to other locations (most often to the USA) for use in a partner's IVF cycle there (Ibid.). Although sex-selective ART developed in the USA as a consumer choice for family composition, it is clearly an unbounded practice that takes place in hubs within globalized fertility market chains. Other scholars confirm the complexity of cross-border sex selection, documenting patient travel to Thailand (Whittaker, 2011), Northern Cyprus (Mutlu, 2015) and Dubai (Kroløkke and Kotsi, 2019).

### France and the USA — Doing and undoing nation via ART

By juxtaposing the long list of ART contrasts between the French and US contexts with which I opened this paper — departure versus destination country, highly regulated versus deregulated governance, medical versus social applications, and access (or lack thereof) via public versus private health insurance sectors — it may be difficult to imagine how these extremes occupy a common continuum of globalized market channels. However, through the case of cross-border and (sex) selective ART, it is possible to see how both the French and the Americans are involved in the undoing and doing of nation via ART as global assemblage. As a participant of the Franco-American workshop

designed to interpret ART in a comparative perspective, I grappled with the assertion of a French perspective on ART or the 'French' way of doing and/or researching ART. Although the 'American' participants were placed in a frame where our nationality was highlighted, and all of our cases were intentionally selected to represent a US context, we did not generally assert our 'Americanness' in the same way. Perhaps an obvious consequence of the relative lack of federal governance of, and federally prompted deliberation on, ART in US society, our perception of nationality in relation to ART diffuses as our state maintains a deregulated status quo.

In France, doctors and scientists sought one of the world's earliest instantiations of state legislation, France's 1994 bioethics law, in order to lift the 'burden of ethical responsibility for the consequences of their own unsettling innovations' to 'society at large' (Fournier and Spranzi, 2013: 41). In the USA, on the other hand, consumer rights, privacy and hegemony of the marketplace, rather than the state, determine ART practice. In her interviews with providers, Martin found, 'By emphasizing the individual right of the consumer (regardless of residence or citizenship) to negotiate with an individual provider about what services will or will not be offered, my informants emphasized the market relationship between provider and client, and deemphasized the role of the state in governing that relationship' (Martin, 2014: 451). 'American' in such a commercialized free-market context functions more as a 'luxury brand' (Martin as quoted in Jacobson, 2019) that signifies the 'ideologies of genetic determinism and consumer choice' that Martin asserts do not 'end at the US borders' (Martin, 2014: 432). The felt presence of the nation in relation to ART is already undone in the US context. The nation will not interfere in private ART practices, nor does it support them in the form of a public health benefit.

However, this 'American' way of doing ART can be remade or redone, for example, by carefully outsourcing clinical practices such as sex selection abroad. As I detail in my book, the outsourcing of sperm sorting via MicroSort abroad involves a lengthy process of locating open 'not illegal' space where professional ART provision guidelines that discourage the practice, if they exist, are non-binding and laws remain unspecified (Bhatia, 2018: 140). Clinical encounters that take place outside of the US geopolitical boundaries can, in this way, take on an 'American' form. Like Grewal's 'transnational America', 'family balancing' is ideally global, able to 'traverse' and 'rearticulate' across national boundaries (Grewal, 2005: 3). Mutlu describes how a Turkish citizen secretly accessing sex-selective ART treatment in Northern Cyprus formulates her desire for a son as 'family balancing'. In this way, she invokes a western (Americanized) form of maternal subjectivity to distance her motivations from biased 'son preference' (Mutlu, 2015: 226).

Similarly, the act of 'civil disobedience' by French citizens compelled to seek law-evading cycles abroad is not only a way of undoing French nationality, but also doing an alternative western or (trans)American one, at least to the extent that Americanized forms of subjectivity signify the assertion of consumer choice and fulfilment of individual desire. As Malmanche argues, the more invisible these transgressions (e.g. a hypothetical heterosexual couple with

a successful sex-selective conception abroad that births back in France), the more likely that costs to the rights and privileges that come with French nationality and citizenship associated with the normative transgression can be limited (Malmanche, 2019). In this way, a breach in the 'French' way of doing ART associated with engaging in tabooed sex selection may be resolved through its surface legibility as a strategy which ultimately adheres to French pronatalism aimed at proliferating traditional heteronormative families. Visible transgressions, on the other hand, as in the case of successful use of gestational surrogacy abroad by gay male couples, can come with structural and societal impediments to acquiring French civil status for the child (Courduriès, 2018).

Therefore, as scholars of globalized ART, a significant take-away lesson from the 'Franco-American' comparative exercise is that, when we take the nation state as a basis for comparison, we must be attuned to ways in which nation can materialize in the form of state structure, just as much as in cultural-economic assemblages or ideologies that breach geopolitical boundaries. In this way, we can perceive the subtle as well as overt ways that nation is done and undone via ART.

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