



Vulnerability When Fecundity Fails: Infertility and Assisted Reproductive Technologies in *The Bridge*

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Citizens' vulnerability with reproduction and the state's responsiveness to vulnerability comes under investigation in season III of *Bron/Broen* (*The Bridge*) from 2015, a Nordic noir television serial that teams up two detectives, one Danish and one Swedish, to solve crimes that have impacted both countries and the cities of either Copenhagen or Malmö. The collaboration engages the greater metro area of the Øresund region, linked since July 2000 by the titular bridge, which the criminals and the police traverse at a dizzying pace. Written by Hans Rosenfeldt and co-created by Rosenfeldt, Måns Mårild and Björn Stein, the Danish/Swedish co-production of *The Bridge* ran for four seasons from 2011 to 2018.¹ It quickly became a domestic and international success; by 2018, it had been aired in 188 countries and remade in other

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nations with unique border relationships such as Austria/Germany, Estonia/Russia, France/UK and Mexico/USA, with another remake under way in Malaysia/Singapore (Chawla 2018). In seasons I and II, Martin Rohde (Kim Bodnia) from Copenhagen is paired with Saga Norén (Sofia Helin) from Malmö, while seasons III and IV bring Henrik Sabroe (Thure Lindhardt) from Copenhagen to be Saga's new work colleague.²

Much has been, and can be, said about the complex primary characters Saga, Morten and Henrik, fallible and fascinating as they are; however, this article focuses not on the main detective heroes but, rather, on the secondary characters woven into the DNA of season III of the series. By my reading, one critical subplot of the third season concerns infertility, including the ways in which individuals counter this life crisis to form families with assisted reproductive technologies (ART), the inconsistencies in ART governance across the Øresund, and the consequences for donor-conceived children. Perpetrators, victims and innocent bystanders wind up caught in the helix of reproduction that revolves around the larger plot arc. *The Bridge* critiques the Danish and Swedish welfare states, and assesses how they handle the embodied vulnerability of aspiring parents' infertility and reproduction now (in the 2010s) and in the early years of ART (in the 1980s), and of the emerging donor-conceived citizenry as they mature as vulnerable subjects.

The case on which Saga and Henrik professionally collaborate has them investigating a series of gruesome murders where the killer arranges the victims' bodies as performative art exhibits that cluster around a loosely defined theme of the family. The wealthy Holst couple, Freddie (Nicolas Bro) and Åsa (Anna Björk), own an art collection that links to the victims' death vignettes. The Holsts also await their firstborn son from secret surrogate mother Jeanette (Sarah-Sofie Boussnina). Saga and Henrik solve the complex puzzle and catch the killer Emil Larsson (Adam Pålsson), whose victims are individuals who represent the institutional injustices he suffered as a child.³ A donor-conceived child who became a ward of the Swedish welfare state, Emil has learned that Freddie Holst was the anonymous donor of the sperm his mother received at the fertility clinic.

Thus, this infertility subplot of season III of *The Bridge* presents a myriad of vulnerable subject positions that, viewed together, critique the efficacy of the responsive welfare state in a cross-border comparison. Because it exists in the transnational region of the Øresund, the series levels criticism at the policy gaps between neighbouring welfare states that breed reproductive tourism and political tension in this imagined space. Success

stories of ART in the early 1980s launched the Nordic countries on a trajectory that has transformed medically assisted reproduction and substantially reduced barriers to parenthood for involuntarily childless citizens. A woman in Sweden in September 1982 gave birth to a baby girl who was the first Nordic in vitro fertilization (IVF) baby, four years after the birth of Louise Brown in the UK. A woman in Denmark followed suit in 1983, when Troels Renard Østbjerg became Denmark's first IVF baby. By 2017, Denmark led European counterparts with a solid margin as the country initiating the largest number of ART cycles in Europe—followed by Belgium, Iceland, Sweden, and Slovenia—according to a study by sociologists Patrick Präg and Melinda C. Mills (2017).⁴ National legislation governing ART varies widely across the globe; Präg and Mills (2017, p. 305) attribute the national variation in Europe most generally to the cost of procedures, the extent of health care coverage for treatments, and the cultural beliefs regarding pregnancy and parenting, although multiple factors are at play.

Governance controls the regulation of and access to ART, and policy discrepancies challenge the claims of equality for health care surrounding infertility. Regulatory differences within the Nordic states have decreased over time as new amendments modify existing laws to keep pace with cultural change around medically assisted reproduction. Historically, Denmark has been most inclusive in ensuring that the broadest swathe of citizens has affordable access to ART. In the words of biomedical researchers Sebastian Mohr and Lene Koch (2016), 'IVF transformed Denmark: the use of reproductive biomedicine became normalized to the degree that access to reproductive health services is not regarded just as an individual matter, but a collective responsibility' (p. 94). Danes have complete health care coverage for ART treatments with national health insurance for single women, cohabiting couples, and married couples of any sexual orientation (Präg and Mills 2017, p. 297).⁵ Sweden only permitted lesbian and single women access to ART in 2016, although it had been legal in Denmark since 2007. Cross-border reproductive care (CBRC), or reproductive tourism, emerged as a logical response to inaccessible and unaffordable ART treatments at home. People who are involuntarily childless and have sufficient resources travel to another country where their desired ART is attainable. Denmark became an ART destination for Scandinavians and many others, and *The Bridge* incorporates this reality, showing the strengths and weaknesses of their system.

I investigate infertility and ART in Denmark and Sweden in the secondary characters from *The Bridge* in conversation with Martha Fineman's (2013) vulnerability thesis and Rachel Anne Fenton's (2013) vulnerability study of the inadequacy of the UK health care system to serve infertile citizens. There are many elements of medically assisted reproduction not addressed in the Scandinavian TV serial, but concerns surrounding sperm and egg donation, anonymity, surrogacy, and donor-conceived origins emerge in the plot and the film narratology. Among the spectrum of secondary characters are the infertile mothers-to-be (Helle Anker, Anna-Maria Larsson, and Åsa Holst) who need donor gametes, the fertile donors (Jeanette, and Freddie Holst) who provide donor gametes and bodies, and the donor-conceived children (Morten Anker, Emil Larsson, Jan Fredrik Holst) who result from the successful ART treatments. The responsive Nordic welfare state has treated citizens differently, overlooking the vulnerability of some of the people in these intentional families; *The Bridge* magnifies those shortcomings for the involuntarily childless in a subplot that reveals the privileges of the partnered and fertile.

EMBODIED VULNERABILITY OF THE INFERTILE IN ØRESUND

American feminist legal scholar Martha Fineman (2013) theorizes that humans are vulnerable, and that the institutions humans create in response to those vulnerabilities mirror the universal condition of dependency: 'I set out an alternative vision for justice by developing the concepts of vulnerability and resilience and articulating an argument for a responsive state—a state built around the recognition of the vulnerable subject' (Fineman 2013, p. 13). Charting an alternate course for legal equality, Fineman advocates for a vulnerability analysis that necessitates a recalibration based on our understanding of the fact that, 'vulnerability is a universal and constant aspect of the human condition. Dependency and vulnerability are not deviant, but natural and inevitable' (Fineman 2013, p. 17). All citizens are equally vulnerable, despite possible status as protected classes, as Fineman believes that identity characteristics often limit state action to help citizens for they become stigmatized and serve as 'proxies for problems such as poverty or the failure of public educational systems' (Fineman 2013, p. 15). As a way to correct gendered inequities of care, Fineman uses 'dependency' to rebalance engrained divisions of labour within the traditional family structure and the state's system of

institutions that ameliorate those caregiving burdens for individuals. Vulnerability can vary, depending on the quantity of resources available to the individual, but individuals never become invulnerable in Fineman's framework.

In recognizing the dependency of the vulnerable subject, Fineman's concept makes individual need visible as a core responsibility of good governance at every administrative level. To serve the vulnerable subject adequately, Fineman calls for a 'responsive state', which she defines as:

a state that recognizes that it and the institutions it brings into being through law are the means and mechanisms whereby individuals accumulate the resilience or resources that they need to confront the social, material, and practical implications of vulnerability. As such, a responsive state also recognizes that it has a responsibility to monitor the activities of its institutions to ensure that they function in an appropriate, egalitarian manner. This progression from vulnerability to state responsiveness incorporates the realities of human dependency. (Fineman 2013, p. 19)

Fineman's responsive state shares many commonalities with the 'cradle to grave' Scandinavian welfare states designed to respond to human vulnerability, including infertility. States' nimbleness and willingness to adapt to changing technologies and social realities clearly varies. Whether or not the growing pressures on the welfare state allow it to maintain the same degree of responsiveness for which Fineman advocates is another question.

British feminist legal scholar Rachel Anne Fenton (2013) operationalizes Fineman's vulnerability framework for reproductive medicine in an analysis of the UK health care system's legislative treatment of the infertile, and finds that the state is inadequate and unresponsive in 'addressing the embodied vulnerability of the infertile—an inadequacy exacerbating conditions of privilege and disadvantage' (Fenton 2013, p. 126). Fenton claims that equality in reproductive health care is illusory, and regards the UK as unresponsive to infertility. The analytical framework established by Fineman (2013) and Fenton (2013) around family, gender and equality in reproductive legislation and policy construct a productive platform from which to launch an analysis of *The Bridge*, and the responsiveness of the Danish and Swedish states to embodied vulnerabilities dealing with fertility.

To reproduce is to be vulnerable, Fenton (2013) argues, and thus one of the essential elements of human existence is universal; everyone is vulnerable to the embodied human condition of infertility, or the inability to reproduce. Fenton acknowledges that infertility, for some, is a major life crisis, and that most individuals encounter complexity surrounding the desire and ability to reproduce. The state also has a stake in individuals' decisions to reproduce and regenerate society; therefore, it is the state's duty to be responsive and to allow all its vulnerable citizens to realize their full potential. For many individuals, realizing that full potential means to become a parent.⁶

While there are consequences at home, Fenton maintains that 'unethical legislative behaviour and the evasion of responsibility to provide genuine equality of access by a nation-state' to ART and fertility treatments also have global ramifications (Fenton 2013, p. 126). Research on CBRC makes evident that some restrictive laws feed market forces that allow only the privileged actors agency in their reproductive choices as resistance against vulnerability. Those citizens with less privilege and fewer resources are excluded. Fenton argues that state behaviours and policies that intensify discrimination ostensibly absolve states from responsibility for the involuntarily childless. Knowing treatments abroad may be more affordable, states may justify their inaction as the best choice for the privileged able to access CBRC—a practice Fenton labels as a highly problematic ethical subversion. Policy on gamete donations may leave the next generation of donor-conceived children unduly vulnerable. Fenton's charge applies to the CBRC between Denmark and Sweden regarding 'the use of anonymous sperm donation abroad which flies in the face of a nationally recognised principle of biological truth—of the possibility for a child to know its genetic origins' (Fenton 2013, p. 143). Even well-intentioned responsive states that provide some degree of resilience against vulnerability in the welfare system may not be suitably equipped for dealing with the growing numbers of donor-conceived children's families, child care, and educational needs.

Attention to these international ART issues has emerged concurrently with the genesis of the Øresund region, so it is fitting that this season's plot interlaces the topics. Pei-Sze Chow (2016) reads *The Bridge* as a product of the 10-plus year investment to generate a unified imagined community of 'Øresund' that linked Sweden and Denmark, and as a critique of the regional social fusion created by the fluid borders between nations (Chow 2016, p. 37). Chow builds on Andrew Nestingen's claim

that the crime fiction genre uses lawlessness as a catalyst for a debate on domestic national character and transnational diplomatic relations. The detectives' mobility traversing the borders resembles a sewing motion that stitches together the region that 'crime then seeks to tear apart' (Chow 2016, p. 46). Chow argues that *The Bridge* is unique because it concentrates those tensions on one region and international metro area that comes into being as the detectives cross borders, both literal and figurative. The concentrated visual space of Øresund is 'the landscape of a transnational metropolis, portrayed as a paradoxically fractured yet seamless urban space that must be traversed to stop the perpetrators' (Chow 2016, pp. 43–44). The literal cross-fertilization of citizens of both nations fits Chow's imagery.

The transnational imaginary pairs well, Chow argues, with the multiple subordinate storylines that the TV serial format enables. One season contains 10 episodes, presenting innumerable opportunities for subplots and supporting characters to enter and exit the story while the primary characters encounter, uncover and solve pieces of the larger plot of the crime narrative. Viewers then see:

a multiplicity and simultaneity of perspectives—subjective experiences of the region through each of these minor characters who typically come from diverse social groups and whose depictions are emphatic comments on topical welfare-state issues pertinent to modern day Denmark and Sweden. [...] Underneath the crime narrative lies a more complex social mapping and characterization of the Øresund. (Chow 2016, p. 46)

Chow's iteration of the formal conventions for *The Bridge* enables an inclusivity of perspectives on ART and a social mapping of welfare state shortcomings surrounding infertility by portraying examples of vulnerable citizens with varying needs and resources. To more fully unpack infertility narratives in *The Bridge* within this vulnerability framework, it is productive to consider the history of ART in Denmark and Sweden. The narrative time of the TV serial is roughly the time of production, but the show embeds some of the pre-series action back in the early years of Swedish and Danish fertility treatments and legislation to inform and exacerbate contemporary consequences.

ART HISTORY—SWEDISH AND DANISH STATE PROVISIONS

Unresolved tensions in the governance of and access to some variants of ART in the Øresund region percolate through the surface of Scandinavian communities, despite many scholars' insistence on the public unanimity around medically assisted reproduction. Sweden receives praise from pioneering scholars within the field of reproductive medicine in an article on the legal aspects of the early history of ART (Cohen et al. 2005). The authors stress the innovative research in Sweden and the public–private collaboration in reproductive medicine as elements of their laudatory beginnings. Advocating early for ART, the first private fertility clinic opened in Stockholm in 1984, two years after Swedish physician Lars Hamberger assisted the birth of the first Nordic IVF baby in Göteborg (Cohen et al. 2005, p. 456). Legislation struggled to keep pace with the medical advancements but, again, Cohen et al. (2005) recognize the Nordic states for creating laws regulating reproductive medicine as it developed. Even though ART legislation can be hailed as ‘a novel phenomenon’ by many, Präg and Mills (2017, p. 295) caution that ‘there is a long history of government interference in the reproductive realm’. Norway and Sweden began passing legislation in the late 1980s, and Iceland and Denmark followed suit in the late 1990s.⁷ The earliest laws tended to be the most restrictive, and there was great variation in ART access and availability between the Nordic states. Cohen et al. state that a noteworthy feature of the Swedish law prohibited anonymity for sperm donors, making it the first country in the world to legislate such provisions (Cohen et al. 2005, p. 455). This no doubt influenced CBRC in the Øresund region, as evidenced in one of *The Bridge* storylines.

Writing this early history after the first twenty years of ART, Cohen et al. compared numbers of ART treatment cycles in their 2005 data set and found that the Scandinavian states had nearly triple the number of fertility treatment cycles compared to the USA and UK that same year. The researchers attributed the extraordinarily high numbers to ‘relatively high reimbursement levels in the Nordic countries and a high public acceptance of the technique’ due to health care benefits in the welfare state and the demonstrated safety of ART treatments (Cohen et al. 2005, p. 456). The collective belief and trust in ART permeated Scandinavian societies, despite national variation in access and regulation. This growing trust is echoed in the Präg and Mills (2017) research into IVF in European states from 2017, as well; together, these two studies suggest a

respectable degree of responsiveness in Nordic states to citizens' vulnerabilities compared to European peers.

While Sweden may enjoy early praise, Denmark surged ahead as a global leader in ART. In a 2016 article on the history of IVF in Denmark, Mohr and Koch argue IVF transformed Denmark from 'a society concerned about the social consequences of reproductive technologies to a moral collective characterized by a joined sense of responsibility for Denmark's procreative future' (Mohr and Koch 2016, p. 88). Echoing Fineman (2013) and Fenton (2013) in the way they frame infertility issues for vulnerable subjects and a responsive state, Mohr and Koch (2016) argue that the acceptance of IVF in Denmark was about more than medical procedures helping involuntarily childless individuals, for it became a 'technology of social contract' that created 'a space of possibility' for negotiations between the state, its institutions and its citizens to construct a unified 'pursuit of procreative futures' (Mohr and Koch 2016, p. 89). Mohr and Koch claim that IVF has become a normalized part of Danish life now, given the relatively high number of children born following ART procedures (8% per year in 2016 in Denmark), allowing citizens to establish families 'whose mode of creation and existence is rarely questioned by either political or media representatives' (Mohr and Koch 2016, p. 89). Danes expect the collective—state and society—to ensure national reproductive futures.

It did not start that way, according to Mohr and Koch. Danes initially regarded IVF with suspicion because of the unfamiliar medical procedures, the reproductive control and the way in which it disrupted established heteronormative family models:

When IVF was introduced, there was harsh opposition to it and a rejection of non-traditional families; once approved, it gained swift acceptance, but non-traditional families still met disapproval; and today, IVF is accessible to (almost) everyone, helping to create all kinds of non-traditional families, with Statistics Denmark currently registering 37 different family types. Thus whereas in the 1970s and 1980s IVF was too controversial to be offered outside of heterosexual coupledness, today IVF marks Denmark as a reproductive collective. (Mohr and Koch 2016, p. 95)

For Mohr and Koch, the societal concerns that dominated the early days of the 1980s were of a medical nature, ensuring that the science was sound. Societal norms and beliefs had changed by the 1990s, and they

argue the focus of the debate had shifted to the state's regulation of access to ART as an equality project.⁸ The overtones to Fineman (2013) and Fenton's (2013) work ring clear. Humans are vulnerable and, around the millennium shift, the responsive Danish state recognized that it must build resilience to serve the citizens equitably and to allow anyone to become a parent.

Denmark's reputation as a 'reproductive collective' is growing, for ART treatments and for gamete donation. Mohr and Koch (2016) reported 21 public and private fertility clinics, and four sperm banks in Denmark. This includes Cryos International, one of the world's largest sperm banks, which began in 1981 as Ole Schou's dream; it eventually opened in Aarhus in 1987 and now has international offices (Petroff 2015). Men's sperm donation is a profitable business, regulated and routine, and the donors receive modest financial compensation.⁹ Stine Willum Adrian and Charlotte Kroløkke (2018) in their study of the reproductive pathways in and out of Denmark attest that, within the industry, Denmark has the reputation of being a fertility nexus due to the leading role the country has played in the development of the industry, and due to the high rate of children born with ART treatments. Compared to difficulties recruiting donors and prolonged waits to procure donor sperm in Sweden and Norway, Adrian and Kroløkke (2018) confirm that 'in Denmark, donated sperm has become an export commodity, enabling the recruitment of both anonymous and non-anonymous donors' (p. 6). Women's egg donation is not a routine procedure and does not have a comparable societal acceptance. Legal since 2006 in Denmark, egg donors cannot receive compensation given laws that prevent the commercialization of these gametes.¹⁰ Adrian advocates equity but states that societal views on gamete donation perceive egg cells as 'gifts', while sperm cells 'move around anyway' (Bajekal 2019, p. 6). The dissimilar treatment of female donors to their male counterparts leads Mohr and Koch (2016, p. 90) to ascribe a gendered legislation to Denmark's gamete donation laws.

As with egg donation, surrogacy remains one of the most contested variants of ART in Denmark and in many other nations.¹¹ Traditional altruistic surrogacy is legal for Danish citizens in Denmark. Gestational commercial surrogacy is prohibited, and excessive compensation can impede legal adoption and transfer of parental rights. The policy environment is currently extremely dynamic in Denmark and in Sweden, and this

controversial issue is a moving target in both countries. The Swedish parliament advised against surrogacy in 2016, based on a report compiled by Eva Wendel Rosenberg (*SVT Nyheter* 2016), and in opposition to recommendations from the Swedish National Council on Medical Ethics (*The Local* 2016): the debate rages on concerning whether or not to allow altruistic surrogacy there (Everingham 2017). The Swedish Green Party advocated for reinvestigating the ban at their May 2019 party convention, yet the culture remains in flux, as demonstrated by the societal debate and the unwillingness to change policy (*Aftonbladet* 2019).

Discrepancies in fertility legislation in Denmark and Sweden, both historical and current, force involuntarily childless citizens to cross borders fluidly in their search for the combination of laws and services that fit their individual needs. The Swedish state's responsibility is negated by the existence of the transnational Øresund region that enables easy movement to Denmark, and thus minimizes issues with reproductive tourism for Scandinavian citizens. Quoting a Swedish couple they interviewed during their research on ART in Denmark, Adrian and Kroløkke (2018) write that in their 'imagination, they are just going to a different town, which makes their negotiation of ethical, legal, and national boundaries appear unproblematic' (p. 12). *The Bridge* portrays this international reproductive tourism and calls attention to the ways Denmark and Sweden perpetuate privilege and disadvantage in reproductive medicine.

THE BRIDGE—INVOLUNTARILY CHILDLESS WOMEN BECOME MOTHERS

Women's embodied vulnerability as involuntarily childless citizens of Denmark and Sweden in the early days of ART plays out in *The Bridge* in the characters of Danish Helle Anker and Swedish Anna-Maria Larsson, while the contemporary situation emerges in Swedish Åsa Holst. Their individual stories portray access to ART, CBRC, surrogacy and the efficacy of the responsive welfare state given ART legislation. Glimpses of their reproductive histories emerge as clues in the 10 episodes of season III. In episode 1, Helle is found dead and Anna-Maria has already died; their ART events precede the narrative time of the series and set the stage for Åsa's narrative. These two women presumably identified as cisgender heterosexuals needing donor sperm to become pregnant when they conceived, and different paths led them to the same donor sample.

It is no surprise that Helle Anker, a pioneering founder of a fertility clinic, would take advantage of the clinic's services; living in a heteronormative marriage, the treatments could be kept secret with no visible societal consequences. Helle Anker was married to Willy in the 1980s, so her use of anonymous donor sperm was uncontroversial and the heterosexual couple's authority as parents to their son Morten (Asbjørn Krogh Nissen) was unquestioned, as Mohr and Koch argue such treatments were in Denmark. 'Positioning donor insemination as an intervention that subscribed to the traditional kinship model, rather than disturbing it, thus secured medical authority over its administration' (Mohr and Koch 2016, p. 91). As the first murder victim in episode 1, Helle's death leaves behind her grieving wife Natalie (Marall Nasiri) and two sons. Given that she was in a same-sex marriage in 2015, her second son was presumably a donor-conceived child, although the show never clarified the biological origins of the younger son. At the time Helle and Natalie conceived, single and partnered lesbian women would have had equal access to ART treatments and health care coverage in Denmark, theoretically making both of Helle's family constructions equally accepted. However, the TV serial narrative casts doubt on the level of acceptance in practice given the turmoil around Helle's family. Helle apparently told Morten his genetic origins, and he pursued and learned the identity of his donor. Helle appears not to have shared that information with her wife, who misinterprets Morten's reaction at Helle's death to 'tell his father' the news.

In contrast to Helle's unquestioned access to ART, Anna-Maria Larsson would have been denied ART treatments for infertility as a single woman living in the late 1980s in Sweden. Sweden's initial restrictive legislation prohibiting single women's access to ART passed a decade before similar legislation in Denmark. 'During this period (1986–1997) of legal regulatory void, [Danish] clinics were free to offer treatment to anyone, including lesbian and single women (later excluded from treatment by the fertilization law)' (Mohr and Koch 2016, p. 92). Anna-Maria circumvented restrictive Swedish law by traveling to Denmark in order to conceive with ART in an early example of CBRC in Øresund. The label 'reproductive tourism' may have been more palatable in that pre-bridge era, when travellers relied exclusively on ferries to carry cars and passengers internationally across the sound. Travel was not difficult, but not as simple as in the post-bridge era. Anna-Maria's marital status is never confirmed, but her son Emil remembers the fantasy-laden stories she told him about his father. Anna-Maria took her reproductive secrets with her

to the grave, in spite of the regulated Swedish state system.¹² Recalling that Swedish law required a known sperm donor, Anna-Maria's choice to pursue CBRC and a donor in Denmark plausibly excluded her and Emil from the IVF statistics in the Swedish system, a factor that may have thwarted the state's ability to address the vulnerabilities of mother and son appropriately. Only the mother's code-protected file at the fertility clinic existed as evidence to confirm these ART treatments and trace the donor identity, which became a hurdle for Saga and Henrik's investigation.

Unlike the fecundity of the 1980s ART histories of Helle and Anna-Maria, Åsa Holst is infertile and she counters her involuntarily childlessness in 2015 by procuring a donor egg and a surrogate womb. A Swedish citizen, Åsa is married to Danish entrepreneur Freddie Holst and the two reside in Denmark. Egg donation would have been legal in both countries when Åsa needed the state to support her health care needs, but surrogacy was not legal in Sweden. The couple's marital status and primary residence outside of Copenhagen eliminated the need for CBRC for the Holsts due to the fluidity of the Øresund region. Åsa apparently identifies as cisgender heterosexual who is married to a fertile Danish man who can provide sperm for the surrogate, thus ensuring the required biological link to one parent, for only traditional altruistic surrogacy was legal in Denmark for Danish citizens at the time. Åsa's embodied vulnerabilities centre around guilt and anxiety at her infertility, rather than the responsive state's inability to address her desire to be a mother; once again, the Danish state (and not the Swedish state) had the necessary institutions in place to conceive and bear the child, thereby successfully fulfilling the Holsts' reproductive dreams.

The visible consequences of surrogacy loom large in the narrative. Åsa performs her pregnancy in public by wearing a prosthetic belly, fearing that people will question her claim to the baby that will be their long-awaited heir. Despite Mohr and Koch's insistence that Danish society was completely at ease with ART and non-traditional family forms by this time, Åsa's behaviour displays suspicion of public opinion in a society ill at ease with the purported insignificance of a child's genetic origins. It may also reinforce pressures to be a mother and conform to underlying ideals for women to reproduce. Åsa's confidence in her glowingly pregnant body at the gala opening of their art collection exists as a jarring contrast to her personal feelings of insecurity around the surrogacy arrangement, which is revealed in the marital conflict that erupts when the couple returns home and the belly comes off. Åsa harbours fears that

Freddie will love the surrogate Jeanette more because she was ‘woman enough’ to bear him a son. Viewers learn Åsa was not planning to meet the surrogate, which speaks to her discomfort with the process, so things became more complicated for Åsa when Jeanette moves into their guest-house in the final weeks of the pregnancy. The surrogate transforms from an abstract idea to a real person carrying their child, and the daily visual reminder of the other woman’s pregnant, fertile body provokes Åsa and infers her physical shortcomings as an infertile woman.

Without a biological link between mother and child, Åsa doubts her ability to bond with her baby and worries that Freddie will always have a better relationship as father to their son because of their shared genetic connection. Åsa admits to Jeanette that she has pretended to be pregnant so that ‘no one will doubt that it is my child’ (*The Bridge* 2015, episode 7). Access, cost and laws regulating surrogacy are irrelevant to Åsa, but the inability to establish genuine parent–child bonds terrifies her. The discrepancy between Freddie and Åsa’s views on surrogacy emerges in a night-time bedroom confrontation (*The Bridge* 2015, episode 7).

Freddie: But Åsa, she is pregnant with our son.

Åsa: But it doesn’t feel that way. It doesn’t feel like mine.

Freddie: We wanted a baby, right? But we could not make one.

Åsa: I cannot have a child. It is yours and hers. I have nothing to do with it. That’s why I didn’t want her living here, to see her. If the child had just arrived, then—but when I see you two together...

Freddie: Åsa, look at it this way. We rent her body for nine months. And then the child is yours. And then we will never see her again.

Unable to look at his face, Åsa stares at Freddie’s back during this confession, and Freddie does not turn to look at her. The camera allows the audience full access to the faces, body language and emotions of both characters during the exchange. Freddie turns to her for his final line, which the camera observes from the hallway, and Åsa nods her silent agreement to his proposition.¹³ His reduction of the surrogate here to a ‘rental womb’ stands in sharp contrast to the care he demonstrates for Jeanette’s personal welfare, hinting at the individual conflicts each parent-to-be wrestles with internally, and the tensions and competing beliefs about surrogacy between husband and wife that may have historical roots in ART governance in Denmark.

In sum, the Danish health care providers, and thus the welfare state, supported all three women to become mothers by providing resilience strategies to overcome their involuntarily childless states, regardless of their marital status and physical needs. Helle and Anna-Maria learned they were fertile and that their physical bodies were not the root of their embodied vulnerability; Åsa had unexplained infertility so she pursued an egg donor and surrogate. The Swedish state failed to support Anna-Maria's journey to single parenthood when she had not conformed to the traditional kinship model of heteronormative marriage and would not have supported Åsa's surrogacy option. The narrative makes no connection between Anna-Maria's death and her ART utilization, but Åsa suffers for her choices. Helle dies as a victim punished for embracing and enabling the reproductive technologies that made her and countless other involuntarily childless women like her into mothers.

THE BRIDGE—SURROGACY AND DONOR GAMETES TO COUNTER INFERTILITY

Donors face a different set of challenges than people with fertility issues; *The Bridge* portrays one female and one male character to tease out these complexities, and how the state generates resilience for their vulnerability. Women's embodied vulnerability as egg donors and surrogate mothers are contested positions in Danish and Swedish society, as previously mentioned. No details are given of Jeanette's recruitment as a surrogate or her ART treatments, which makes it difficult to analyse how responsive the Danish state has been to her. The surrogacy narrative, as all the other ART treatments in the TV serial, exists exclusively in Denmark. Jeanette presumably identifies as a cisgender heterosexual in a cohabitating relationship; economic incentives appear to have motivated her choice to carry the Holsts' child.

The Bridge accentuates the worst fears of domestic surrogacy in Danish society—that it could physically or psychologically harm the surrogate and that it could become commercialized, and thereby a legal form of human trafficking. Jeanette's character has no last name, another sign of her status as a body for hire. Recall that traditional altruistic surrogacy is legal in Denmark, meaning the Holsts' child was presumably conceived with Jeanette's egg and Freddie's sperm by IUI or IVF. In the legal arrangement on paper, Jeanette will receive no compensation beyond her expenses. Off the record, Freddie compensates Jeanette handsomely, with

a lump sum for her boyfriend Marc (Michael Slebsager) to keep his distance and the deed to a rural farmhouse Jeanette dreams of moving to after the birth, in addition to a pre-arranged sum of half million kroner after the birth (*The Bridge* 2015, episode 7). Although she infrequently entertains notions of keeping the baby, remembering the promised financial compensation at delivery helps Jeanette keep her eye on the prize. Jeanette rarely thinks of herself as ‘mother’ to the baby she carries yet, as she observes Åsa and Freddie’s marital tensions escalate, she doubts that Åsa will love the baby because the child has half of her genes. In a call to Marc, Jeanette uncharacteristically calls the baby ‘my child’ and Marc refutes her claim to ownership. Freddie generally calculates the financial risk and investment with the surrogacy, much as in the aforementioned conversation with Åsa. When Freddie therefore calls her ‘the best gift’ because she will enable him to become a father, Jeanette coldly responds that this act is a ‘business deal’ without emotions (*The Bridge* 2015, episode 7).

The surrogacy arrangement ends, Jeanette lives, and so does baby Jan Fredrik. Freddie and Åsa visit Jeanette in the hospital with their son, but she refuses to see the baby or speak with Freddie at the final transaction. *The Bridge* hardly advocates for surrogacy, as it illustrates manipulation of state legislation, as Fenton (2013) argues, that amplifies citizens’ privilege and disadvantage. The Holsts’ extensive wealth signals that anything can be procured for a price, even in Denmark with its progressive regulations and a state responsive to fertility needs.¹⁴ Their wealth clearly sets them well above the average Danish couple, and thus their extortion of a woman from a lower socioeconomic class as egg donor and surrogate feels suspect. Given the trauma of the final episodes, Jeanette seems unlikely to repeat her altruistic act at any price.

Men’s embodied vulnerability as sperm donors is uncontested in society, reminiscent of the commonness of the process Adrian and Kroløkke (2018) cite. The Danish state appears adept at addressing the vulnerabilities of male sperm donors during the donation process. Freddie serves both roles as donor and intended father; his attitude toward both roles could not be more dissimilar. Identifying as a cisgender heterosexual then and now, Freddie is as fertile in the 2010s as he was in the 1980s when he first donated sperm. The difference is that Freddie Holst now wants a biological son as an heir to his fortune, and he has gone to great lengths to facilitate the surrogacy. The unborn child is invaluable to him, and Freddie does everything in his power to love and navigate his wife Åsa’s

emotional behaviour and to keep their surrogate Jeanette safe. Arguably the most privileged character, Freddie reaps the benefits of the welfare state; he encounters complexities to become a parent, but the combined status of his citizenship and his financial resources ensure that he can fulfil his desire to be a parent.

Freddie has no memory of having donated sperm in his past, and is equally clueless that he was the anonymous sperm donor that both Helle and Anna-Maria chose at the fertility clinic in the 1980s. This intriguing twist juxtaposes the value of his donated sperm and the biological link to his genetic offspring; he chooses when and which children to claim. Freddie suffers consequences as an early promoter of ART, not for the challenges he faced to give gametes, but for the nonchalance associated with his individual decision. Perpetrator Emil is not a mirror or spokesperson for any one Øresund society, but his perspective does question the attitudes to donated gametes and the donor-conceived children they produce. Freddie manipulates the Danish regulations for surrogacy arrangements, but that is a secondary issue for the perpetrator. Like Helle, Freddie was to become a victim punished for aiding others' intentional family formations.

THE BRIDGE—DONOR-CONCEIVED CHILDREN AND RESILIENCE

Departing from the concerns of the involuntarily childless and the fertile donors, this vulnerability analysis of *The Bridge* turns, in closing, to the needs of the donor-conceived children. As previously stated, there are three featured characters—all males—born to parents requiring some form of reproductive medicine to bear children: Morten, Emil and Jan Fredrik. While I read the primary focus of the infertility subplot to rest with the parents' generation, the revelation that Emil is the killer reinforces the idea that the donor-conceived children also require attention and equitable treatment. Both wrestling with mental health issues, Morten and Emil's unfulfilled needs as adults contribute to their instability and outreach to donor Freddie as a 'father' figure. These identity characteristics appear to stigmatize these children, and in *The Bridge* they are portrayed as proxies for systematic inequities of care. The narrative hints that life for donor-conceived children was riskier than for those who could trace their biological roots, secure in identity and genetic lineage.

Morten Anker is an Afghanistan war veteran suffering from PTSD. Portrayed as a substance-dependent recluse, his mental struggles back in the relative safety of Denmark stem from war trauma and an unexplained military punishment linked to sexual deviancy while on tour. From Helle's fertility clinic code, Morten has learned the donor's identity, discovered his genetic half-siblings and contacted them to reveal the truth of their origins. He elevates Freddie to a father figure in his mind, and visits the Holsts' house in a failed attempt to meet him. Morten reportedly references 'his brother' in his dying breath, which confounds the detectives until they confirm the shared sperm donor.

Emil Larsson, orphaned at the age of five when his mother died, grew up feeling powerless and manipulated by the system. A foster child that fell through the cracks of the responsive Swedish welfare state, Emil was allegedly abused in the home of his foster parents Filip and Inger Jonsson, confirmed as a victim of sexual abuse by a teacher at school and misunderstood as a ward of the state (*The Bridge* 2015, episode 8). As an adult, Emil becomes the puppeteer controlling the elaborate murder plan and composing the post-murder scenes. Emil calls Freddie Holst and Helle Anker his 'creators' and his stated motive for revenge against all his victims is not to punish but to 'right a wrong' done to him, to 'create beauty', and to bring 'justice' to a tainted past (*The Bridge* 2015, episode 10). Like Morten, he values biological connection to the extent that 'donor' equates to 'father' in his mind.

Jan Fredrik lives, but there is no sign during the final surrogacy transaction that Åsa and Freddie will share his origin story, or allow Jeanette to be part of their lives. If, indeed, Danish and Swedish societies are becoming increasingly comfortable with the medical, legal and social aspects of ART for involuntarily childless adults, then *The Bridge* contests that the conditions for their donor-conceived children are as equitable. Societal change and state attention to these citizens have not kept pace, leaving protective welfare state institutions unsafe in the world of the TV serial. This could be a trait of the Scandinavian crime fiction genre, demonstrating the general demise of the welfare state following the tradition in Swedish crime fiction since Sjöwall and Wahlöö, or it could be a projection that donor-conceived children's vulnerabilities remain underserved. Secrecy around ART and stigmatization of reproductive medicine does not build resilience for citizens, and one could argue that *The Bridge* subplot leaves donor-conceived children in jeopardy of uncertain futures.

CONCLUSION

Fineman (2013) states that all humans are vulnerable and the responsive state helps to build resilience for its citizens; while the Scandinavian welfare states agree in principle, infertility and reproductive medicine show the treatment is unequal. Fenton (2013) argues that the state, vested in the reproductive futures of its people, addresses inequities by providing necessary fertility treatments to those wanting to be parents. Season III of *The Bridge* shows reproductive vulnerability in its cast of characters, and portrays the Øresund welfare states today as largely responsive to those needs. The Danish state, then and now, has been quite responsive in the field of reproductive medicine, while the Swedish state has had room for improvement to match the resiliency to infertility offered across the sound. Given the growing trend of fertility postponement across Europe and in many other countries, policies ensuring equity of access to ART will help individuals address infertility and aid nations trying to increase fertility rates. Even today, some policy differences in access to and regulation of infertility provisions in health care services and insurance policies threaten vulnerable citizens' fundamental rights in the Øresund region and propagate CBRC, the consequences of which are mitigated by the imagined space of the transnational region. The infertility subplot of *The Bridge* portrays how state health care legislation and systems—and, *ergo*, states themselves—perpetuate privilege and disadvantage in ART, further exacerbating the vulnerabilities of involuntarily childless individuals, fertile egg and sperm donors and surrogates, and donor-conceived children. While many point to Denmark and Sweden as exemplary models for current ART policy and practice, historical inequities surrounding the stigmatization of infertility exist and persist in some iterations today. Season III of *The Bridge* continues the crime fiction tradition of finding holes in the safety nets constructed by responsive Scandinavian welfare states to aid their vulnerable citizens.

NOTES

1. Henrik Georgsson and Rumle Hammerich directed season III.
2. Acclimatizing to a new partner at the start of the third season, Saga begins a relationship with Henrik at the office and later at home. Saga's estranged parents make contact with her, her dearest friend and remaining family members die, and her colleagues question her credibility following an investigation by her new interim boss. Henrik secretly abuses substances to

cope with the loss of his missing wife and daughters, and he hallucinates their presence in the family home, which he has kept unchanged since their departure six years ago. Saga and Henrik grow increasingly reliant on each other as the season evolves, with some unexpected twists. Seasons III and IV raise the stakes on the parenting narrative for Saga and Henrik, infusing their lives with intriguing parallel problems that fall outside the scope of this article.

3. Mimicking works of art, his performative display ART-related ‘installations’ of the victims could be read as a poor pun on the medical reproductive subtext.
4. This includes in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), frozen embryo replacement (FER), preimplantation genetic diagnosis and screening (PGD), egg donation (ED), and frozen oocyte replacement (FOR). Intrauterine insemination (IUI) is another ART option.
5. Mohr and Koch (2016) specify that the provision of three cycles of ‘IVF treatments are covered by the tax-financed Danish public health service for all involuntarily childless women residing in Denmark up to the age of 40’ but prohibits ART treatments for women over 45 (p. 89).
6. The state’s interest in its citizens’ fertility gained media attention in Norway in January 2019 when Prime Minister Erna Solberg addressed the nation’s reproductive futures. In her New Year’s speech, Prime Minister Solberg reminded Norwegians that every woman needs to have more than two children in order to maintain the national population and carry the increasingly heavy welfare state into the future. By Fineman’s metrics, the speech may be read as a conscientious leader monitoring outcomes and shortfalls of the system. Solberg’s speech hints at the challenges of infertility without mentioning ART. Veiling ARTs as ‘conceived with help from the health care system’ was, by my reading, a missed opportunity to recognize the vital role of reproductive medicine as a resource for the involuntarily childless (www.dagbladet.no/video/YUHktnmOJgE). Solberg’s call to have more babies is also an intriguing epilogue to a piece of failed ART legislation from May 2018 to bring gender equity to egg donation. Norwegian laws are generally more conservative than their Nordic neighbours; there is not equity of access for all, so those involuntarily childless with sufficient resources must travel abroad to seek CBRC.
7. Cohen et al. (2005) site the years as Norway—1987 (revised 1994); Sweden—1988; Iceland—1996; Denmark—1997; and Finland—no laws in 2005, when the article was published, but 2006 appears to be the first law on ART in Finland (www.finlex.fi/en/laki/kaannokset/2006/en20061237.pdf).

8. Referencing Lone Schmidt's (2006) research on infertile Danish couples, Mohr and Koch (2016) state 'IVF makes infertility and childlessness legitimate subject positions in a society which perceives having children as an important rite of passage into adulthood. The central role of IVF is thus to give people hope that they too may join a collective invested in the common good of having children' (p. 93).
9. In Denmark, sperm donors in 2019 received between US\$40–75 per donation, primarily for their 'time and inconvenience' (Bajekal 2019, pp. 5–6).
10. Egg donation remains illegal in Norway and became legal in Sweden in 2003. Embryo donation and double donation of egg and sperm became legal in Sweden in January 2019 (www.kunskapsguiden.se/barn-och-unga/Teman/Samtal-med-barn-om-deras-genetiska-ursprung/Sidor/Fakta-och-regelverk.aspx) Denmark legalized double donation in 2018 (Folketinget 2017, www.ft.dk/samling/20171/lovforslag/l60/index.htm).
11. *Traditional surrogacy* means the impregnated woman is the genetic donor of the egg that has been fertilized by sperm procured from a donor or a donating father. *Gestational surrogacy* involves double donation requiring both gametes; the fertilized embryo, conceived by donor egg and donor sperm with no genetic connection to the surrogate mother, is transferred to the body of the surrogate, often called the 'gestational carrier'. When the pregnant woman receives no compensation for her labour beyond expenses incurred during pregnancy, the surrogacy is labelled *altruistic* or *non-commercial*. In *commercial surrogacy*, the pregnant woman receives compensation for her expenses plus an additional fee for giving birth.
12. Cohen et al. (2005) admire the ability of the Swedish state to conduct longitudinal studies of donor children and their medical risks due to the data gathered on citizens in national health registers and ART treatments (p. 457).
13. Mohr and Koch (2016) reported that Danish law previously banned surrogacy for 'egg donors are not recognized as mothers, while surrogates, on the other hand, are considered to be mothers in so far as they have given birth, no matter what the genetic connection between them and the newborn' (p. 90).
14. Some Danes and many Swedes rely on CBRC in countries with more permissive surrogacy laws such as Russia, India and the United States.

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