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Fertility and the Workplace: The Role of the Firm, Society and Government in Supporting Reproductive Healthcare

Work–Life Fragility, Dilemmas, and "Gambling" at the Intersection of Fertility Treatment and Employment

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ABSTRACT

Infertility is a working age population issue, meaning that many individuals undergoing fertility treatment are also in paid work—having to navigate conflicts between two often "greedy institutions," which can both bring precarity. Traditional approaches to examining the work–life interface, focusing mainly on temporal issues, fail to account for the multifaceted nature of conflict at the intersect of fertility treatment and work, including its embodied and political nature and how individuals navigate work–life dilemmas. We suggest that Lefebre's *rhythmanalysis* offers potential for extending work–life theorizing and that it can be used, including as elaborated by Toyoki et al., as a conceptual toolkit to generate discourse and action on this less well understood topic. Drawing on biographical narrative interview data from workers in higher education employment, we highlight the myriad challenges individuals try to navigate and offer the concept of "work–life fragility" to better account for individual positioning. Work–life fragility concerns a situation in which (1) two unstable and precarious rhythms intersect, creating multifaceted arrhythmia; (2) there is an individualization of responsibility for addressing arrhythmia; and (3) individual strategies provide only "fragile synchronicities" due to fallible resources, which amplifies feelings of insecurity. Our paper concludes with implications for the design of policy and practice, going beyond time off work for fertility treatment appointments to address embodied risk and psychological tolls; to provide support for decision-making; and to modify systems to help mitigate long-term career impacts. This should better support affected workers, and start to shift responsibility for mitigating/resolving arrhythmia off the shoulders of individual staff alone.

1 | Introduction

> I think I explained it as gambling everything I had, so financial security, my career, my relationship, potentially even my health, well I'm going to gamble that and likely lose.
>
> (Gabby, Post-doc researcher)

Despite a substantial body of scholarship on the interface between work and family or "life," there remain gaps in theorizing, which lead to deficits in organizational policy and practice. For a start, there is an over-emphasis on a narrow conception of the nonwork domain, namely the parenting of young children (Kelliher et al. 2019; Powell et al. 2019; Wilkinson et al. 2017), to the neglect of other experiences, challenges, responsibilities and identities. This is accompanied by a narrow conception of work, which does not fully account for the precarity and fluidity that characterizes much contemporary employment (Warren 2021). Although "work–family conflict" (Greenhaus and Beutell 1985) has proved a crucial concept for work–life scholarship, conflict theorizing does not fully account for the potentially multifaceted nature of incompatibilities, and indeed distress, in certain work–life

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interfaces. Most work–life conflict theorizing has focused on temporal issues (time squeeze and poverty), strain and behavior. More recently, studies have highlighted issues such as emotional support and financial concerns (Wilkinson et al. 2017) and stigma-based work–family conflict (Sawyer et al. 2017). Attention has also been drawn to the "dilemmas" that can arise concerning time and energy investment in a context of constraints and legitimacy concerns (Wilkinson et al. 2017). However, certain facets of work–life experience remain under-explored, including bodily conflict (Gatrell 2007; Jammaers and Williams 2021), how this intersects with temporal, spatial, and financial conflicts, and how dilemmas themselves—and responses to dilemmas—impact individuals. Another critique concerns the lack of emphasis in work–life theorizing on the power relations and sociocultural structures that drive both work and nonwork life, with much work–life scholarship taking an individualistic focus (J. C. Williams et al. 2016).

In this paper, we draw attention to a less well understood topic at the work–family interface: how employed individuals navigate fertility treatment. We also aim to show how Lefebvre's (2004) *rhythmanalysis,* including as elaborated by Toyoki et al. (2006), can provide work–life scholars with a conceptual toolkit for better understanding such a complex work–life interface, which implicates bodily, temporal, spatial, financial and stigma-based work–life conflicts, complex power relations, and which brings significant dilemmas concerning the investment of time and energy.

One in six people globally experience infertility (WHO 2023) and in the UK, around 55,000 patients undergo more than 83,000 fertility treatment cycles per year (HFEA 2023). Fertility treatments—especially the more invasive protocols like in vitro fertilization (IVF)—are logistically, physically, and emotionally demanding processes. With IVF, the treatment cycle starts with frequent (often daily) interventions aimed at monitoring and controlling the menstrual cycle—blood tests, scans, and medication injections. There are strict timetables but also unpredictability, as timings in the process depend on bodily responses. Unpredictability also comes in the form of side-effects that may or may not be experienced, including ovarian hyperstimulation syndrome, bloating, headaches, hot flushes, and mood swings (NHS 2021).

There is also significant fragility in fertility treatment, as a cycle could fail at multiple points. The fertility treatment success criteria is live birth, but IVF has only a 23% success rate in the UK (HFEA 2021), dropping below 5% for women aged 43+ using their own eggs. Many people undergo multiple treatment cycles, and due to limitations in public funding, this can become incredibly expensive (Wilkinson et al. 2023). Navigating fertility treatment has been described as enduring "cycles of dreams, despair and desperation" (Patel et al. 2018), which can carry significant mental health consequences (i.e., Sax and Lawson 2022). These are often private struggles, as infertility and accessing fertility treatment are considered personal issues, and significant stigma remains (i.e., Zou et al. 2025), especially where infertility or fertility treatment intersects with other facets of identity such as age, culture, religion, sexual orientation, relationship status, or disability.

Scholarship is beginning to shine a light on the lived experience of navigating this "all consuming" experience alongside employment, emphasizing issues such as identity threat and transition (i.e., Mumford et al. 2023; Basir et al. 2025), disclosure decisions (van den Akker et al. 2017), financial pressures (Hanna and Gough 2020), and career impacts (i.e., Ichikawa et al. 2020). There is also useful theorizing around the multi-billion-dollar global fertility industry and its influence upon individuals (Cervi and Brewis 2022), and some of the controversies arising from employer interest in fertility treatment (Wilkinson et al. 2023). However, more needs to be done to understand the work–life interface for those navigating fertility treatment: the nature of work–life conflicts, the effects of the power structures underpinning those conflicts, and what this means for "work–life articulation" (Crompton and Brockmann 2006; Smith and McBride 2021)—in terms of the experiences, strategies, and practicalities of affected individuals. This can then inform more comprehensive organizational supports.

In this paper we ask how those employed in a demanding and yet precarious work context—UK higher education (HE) employment—navigate the high-stakes, unpredictable, private, heavily embodied experience of fertility treatment? What are the conflicts and dilemmas, and how do individuals respond? We use key concepts from rhythmanalysis (from Lefebvre 2004; Toyoki et al. 2006) to explore work–life dynamics in the biographical narrative interview accounts of HE workers with experience of fertility treatment. We present our findings in two-parts: firstly, the multifaceted nature of arrhythmia, which encompasses temporal, spatial, bodily, and financial conflicts—and over different temporal orientations, and secondly, participant sense-making, response strategies, and consequences.

Building on Wilkinson et al.'s (2017) concept of work–life dilemmas, we offer the concept of "work–life fragility" to help elucidate the recursive relationship between insecurity/precarity in each domain, multifaceted work–life conflict, dilemmas at the work–life interface and constrained agency. The paper extends our understandings of the gendered politics of everyday life for an increasing group of individuals.

The paper progresses with a focus on rhythmanalysis, and its utility for exploring this specific work–life intersection. We then present the research context and methodological approach before setting out our analysis and discussion. In the conclusions section, we explain what the work–life fragility concept means for organizational policy and practice, which requires thinking beyond time off for fertility treatment appointments to consider the myriad forms of work–life conflict and the vulnerable, isolated positioning of staff navigating this journey.

1.1 | Conceptual Framing: Rhythmanalysis, Gendered Arrhythmia, and Constrained Agency

Rhythmanalysis was first articulated by French sociologist and philosopher Henri Lefebre, through a posthumously published essay collection called *Rhythmanalysis: Space, Time and Everyday Life* (2004). It revolves around the principle that various parts of life are made up of rhythms—recurring patterns

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of behavior across time and space (Toyoki et al. 2006), punctuated by moments of disruption. Lefebvre distinguished between natural, circular (circadian) rhythms and man-made, mechanical (linear) rhythms like the working day. Rhythmanalysis concerns how rhythms of everyday life relate to one another. When multiple rhythms come together, they can either complement each other, termed "eurhythmia" (creating a sense of harmony/normalcy) or be unstable, conflicting or unpredictable, termed "arrhythmia." This is useful for synergies with "work–life balance" and "work–life conflict" concepts.

Lefebvre's interest in everyday life included the work–life interface, "secret"/private versus public rhythms (2004, 15), and interactions between agency and constraint. In his view, everyday life had become simultaneously fragmented and regimented—splitting space–time between work and home, work and leisure, and between what he called lived and constrained (or "compulsive") time (Lefebvre 2005, 53, 58–59). Power and politics are thus central to Lefevre's writing. Horton (2005, 159) observed that the Marxist roots of his analysis were "rarely far from the surface," with everyday rhythms being said to be produced "by the structuring rhythms of the state and capital." Lefebvre believed that capital constructs itself on contempt for the body—on domination and exploitation. He also asserts that it pushes the private to the fore—in terms of individualization of responsibility for conforming to and reconciling rhythms—despite being a public monster.

The concept of "dressage" (Lefebvre 2004, 26) is core to his theorizing—referring to the disciplining and training of the body (by others and the self) to fit the mechanical repetition of capitalist production rhythms. There is a close comparison here to Foucault's (1977) *Discipline and Punish*. When discussing abstract, quantitative time, and "dressage," the rhythms of employment and the workplace are often a key reference. Indeed, Lefebvre (2004, 39) observes that "work remains to a large extent essential … the reference to which we refer everything else back." Workers are trained to turn up at the workplace on time and exert maximum effort. However, importantly for this paper, abstract, imposed time, and "dressage" are relevant for thinking about contemporary engagement with fertility treatment and the strict rhythms of the fertility clinic/industry as well.

Cervi and Brewis (2022, 8) note that fertility industry organizations "while focused on reproducing bodies, also influence, compound, and challenge notions of the bodies they are involved with." Fertility industry discourses are shown to send messages about the nature of the nonreproductive body as pathological (medical condition), emotionally distressed, and in need of both care (from the clinic) and responsible for "self-care." The latter shifts at least some of the responsibility for success onto the shoulders of the individual and implicates "dressage." As Cervi and Brewis (2022) note, individuals are expected to both relinquish agency to the clinic, but also take the necessary steps to maximize their chances of treatment success, by managing their lifestyle and adhering to strict treatment regimens.

Lefebvre has been criticized for not taking gendered inequality adequately into account; hence, feminist approaches have emerged which highlight gendered rhythms (Reid-Musson 2018), including at the work–life interface (i.e., Thorpe et al. 2023), and how risk and vulnerability can be borne at the level of rhythms. Workplace rhythms are known to be inherently gendered. The "ideal worker" (Acker 1990) is masculine, unemotional, and unencumbered by care responsibilities. Women at work are therefore required to mold themselves temporally, spatially and emotionally to the expected norms. They are also still expected to perform the care work required to maintain society. Engagement with fertility treatment is also heavily gendered, with most fertility treatments implicating the female body. Fertility treatment also muddies distinctions between capitalist ("compulsive") time and home/leisure/consumption ("free" or "lived time"), and between alienation and utopia.

Building on Lefebvre's work, Toyoki et al. (2006) offer useful analytical concepts for consideration of agency and constraint at the work–life interface. They note that social rhythms are comprised of an interaction between governance regimes (institutionalized sets of recurring connections between social roles), cultural schemas (generalized notions of appropriate patterns of action), resources and individual agency over time. In rhythmanalysis, agency has a specific temporal orientation, being either past-focused repetitive/routine (to preserve existing rhythms), practical-evaluative (creating new solutions in the present), or projective (with reference to the future). Although social change is always possible, Toyoki et al. (2006, 104) argue that most agency is directed at preserving existing rhythms. They add that "it is not just routine but also practical-evaluative and projective agency (rhythm) through which we negotiate and construct ontological security" (110). But what happens when an individual has little control over outcomes, and rhythms are unpredictable and unstable?

We argue that Lefebvre (2004) and Toyoki et al. (2006) together provide a useful conceptual toolkit for exploring the complex embodied work–life interface experienced by workers navigating fertility treatment.

2 | Context and Methodology

2.1 | Research Context

This paper focuses on higher education (HE)—an interesting employment context for the phenomenon under exploration, as much like the fertility industry, it can be seen as a "greedy institution" (Bone et al. 2018) which requires huge time and energy investment, and yet with little guarantee of a return, with the sector becoming increasingly precarious (Gill 2013).

Within HE, the daily working pattern is often nested inside rhythms of teaching, assessment and student support (units, terms, and academic years), and/or research (experiments, projects, conference seasons, and "REF"[1] cycles). Some working in HE enjoy a degree of autonomy and flexibility (Swanson and Johnston 2003)—resources often considered important for accommodating nonwork commitments. Traditionally, there were also quieter periods in the annual cycle. However, there is

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evidence of an increasing pace/tempo to academic work (Ylijoki 2011; Berg and Seeber 2016) and removal of "down time" (i.e., over summer). Ball (2003, 215) refers to the transformation of public education into a metrically governed enterprise facilitated by "the market, managerialism and performativity." Pressures come from diversification of teaching programs and delivery methods, increasing student numbers, and research mandates to secure external funding, keep publishing, and deliver on the new REF impact agenda (Billsberry et al. 2019). Furthermore, the key rhythms comprising many academic jobs (i.e., teaching, administration, research, leadership, and student support) often clash, with time for research being squeezed (Shaw and Blazek 2023)—something dangerous for career progression within a cultural schema of "publish or perish" (Miller et al. 2011). Many in HE work on insecure contracts, with early career and female academics particularly vulnerable to precarity (McKenzie 2022).

Scholarship has highlighted the incompatibility between HE employment and motherhood/parenthood (i.e., Rosa 2022; Raddon 2002; Hardy et al. 2018), despite employment law and university policy aimed at mitigating disadvantage. It is noted that the disembodied and unencumbered "ideal academic" (Fotaki 2013) sits at odds with the lived reality of maternity/parenting, with the latter limiting engagement with activities required for career progression, namely networking, publishing, and securing research grants (i.e., O'Shea et al. 2023; J. Williams and Mavin 2015). Affected employees are also subject to stereotyping, discrimination and attitudinal barriers, with issues exacerbated for early career scholars and those insecurely employed (Rosa 2022). One autoethnographic paper has highlighted the lived experience of navigating a fertility treatment cycle as an early career scholar (Griffiths 2021), revealing logistical and emotional incompatibilities and calling for further research. We suggest that rhythmanalysis offers a useful lens for exploring the complexity of the phenomenon.

2.2 | Dataset Generation

Data comprises in-depth biographical narrative interviews from a project exploring the bidirectional relationship between self-defined "complex fertility journeys" and employment (n = 80). As the first major empirical research study on this topic, the aim was broad: "To explore how men and women situated in different workplaces and roles, and from varying social backgrounds, experience diverse fertility journeys and to explain the effect of work on preconception/infertility experience, and vice versa." Qualitative approaches are fruitful for uncovering "the messiness of real life" (Braun and Clarke 2013, 20), and biographical narrative interviewing encourages accounts of pathways of experience in context. Ethical approval was obtained from Manchester Metropolitan University Business and Law Research Ethics and Governance Committee (ref: 20547).

Calls for participants were made through the researchers' social media accounts, a Facebook group for women in academia, and a discussion board administered by a leading UK fertility charity. Snowball sampling was also used. The definition of complex fertility journey was kept intentionally broad, leaving it open for participants to decide what this meant to them. In advertising material, reference was made to "deciding if/when to try for children; trying for children; fertility tests; fertility treatment; pregnancy loss; secondary infertility, and involuntary childlessness." We also made it clear that we were interested in a range of occupational and job contexts.

We initially planned to interview 60 individuals, but extended this to 80 as novel insights were still emerging and individuals had trusted us with details of their deeply personal stories in initial email contact. Although the sample was predominantly women (n = 67) in heterosexual partnerships (n = 69), we included 13 men, six participants in same-sex partnerships, and five women pursuing solo motherhood. In terms of the nature of the fertility journey, 37 participants were still engaging with fertility treatment and/or decision-making at the time of interview, whereas 43 had completed their fertility journeys, either with children (n = 21) or remaining childless (n = 22). The sample included diversity in employment sectors, industries and occupations, seniority, working environments and contract types. Many participants cited more than one job context in their narrative. The dominant job classifications in the sample were managerial, associate technical, and professional.

Although a pilot study was conducted in 2018, where most interviews were in-person, the majority of the interviews were conducted remotely (through MS Teams, Zoom or rarely telephone according to participant preference) in 2020/2021 during pandemic lockdowns. Interviews were conducted by the lead or second author, typically lasting 60–90 min.

Each interview began with an open question designed to induce narrative (Wengraf 2011). Participants were asked to tell the story of their complex fertility journey and how this intersected with their employment, starting wherever they chose and taking as long as needed. This allowed each participant to identify and explain personally relevant experiences. Following this, participants were asked to elaborate on elements and/or asked additional questions as appropriate. Although we did not originally intend space–time–energy rhythms to be the focus of the interviews, the biographical narrative approach enabled us to capture the way in which past, present, and future collided in participant experience and also sense-making around options and decisions. Both interviewers revealed aspects of their own identities in the context of building rapport and responding to participant questions about motivation for the study, and we received feedback that the interview experience was positive (i.e., "therapeutic" and "cathartic") for participants. Interviews were audio recorded and professionally transcribed.

2.3 | Data Analysis Approach

The first rounds of data analysis were not conducted with this specific paper in mind. The lead and second author engaged in thematic analysis for key themes for the project and funder reports, and during this process (and presenting key findings in research seminars) the issue of "precarity" became an area of interest, initially with reference to participants in academic employment—bringing us toward the research questions

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underpinning this paper—navigating two rhythms which are intense and yet unstable. As we had a substantial number of participants working within HE in the sample (n = 18, 22.5%),[2] but also at different career stages, in varied job roles, and on varied contract types, we thought this subset would be interesting for a deeper focus—looking specifically at rhythms, work–life conflict, and response strategies. In the sub-sample, all but one participant was female, and most (16) had experience as the fertility treatment patient. Three participants spoke from the perspective of the partner (one had been both patient and partner at different points in her journey). Sub-sample participant characteristics are available in Table S1. To maintain confidentiality, pseudonyms were allocated. Qualitative studies using rhythmanalysis often feature small samples, subsets of datasets, or vignettes (i.e., Barber and Neis 2021; Rouse et al. 2021), reflecting the detailed examination of rhythms and their intersection over time. A single industry suited the Toyoki et al. (2006) conceptual framing, which encourages consideration of specific governance regimes and cultural schemas, as well as resources and agency. There is also a significant body of literature on motherhood in HE with which to compare insights.

Data analysis of the interviews for this paper was informed by Braun and Clarke's (2012) reflexive thematic analysis (RTA), which is compatible with the assumptions of rhythmanalysis. Firstly, the lead author re-read the transcripts to re-familiarize with the narratives, before working through the transcripts to generate initial codes (semantic and latent) and then themes, with a focus on participant's accounts of engaging with fertility treatment, the fertility treatment–work interface, and how they responded to conflicts. Emotions and dilemmas were key themes crafted at this stage. Braun and Clarke (2019) make it clear that RTA rarely falls cleanly into an inductive or deductive approach, with many researchers using both. This was true for us. Following Thorpe et al. (2023, 1558) the lead author engaged in RTA "in dialog with rhythmanalysis"—moving back and forth between the initial codes and themes and the theoretical concepts, including the concepts of rhythms, arrhythmia, and dressage from Lefebvre (2004) and governance regimes, cultural schemas, resources, and temporally informed agency from Toyoki et al. (2006). Table S2 shows the levels of coding/theme development. At various points throughout the analysis, the lead and second authors discussed, defined, and named the themes, moving iteratively between the data and literatures. A further process concerned discussions between the authors as to how the themes fit together in terms of the multifaceted nature of arrhythmia, types of agentic strategy, and the very vulnerable positioning of individuals.

3 | Analysis and Discussion

3.1 | Multifaceted Arrhythmia and Work–Life Conflict

Fertility treatment could be seen as both an arrhythmia (as with Thorpe et al. [2023] on the disruption of COVID-19) and a new nonwork rhythm to try to manage alongside the work rhythm, often causing specific challenges (arrhythmias) at the work–life interface.

Needing and accessing fertility treatment posed a significant disruption to expected, "normal" nonwork rhythms for participants. Catherine described fertility treatment as a "shock," whereas Nicola described it as "just incredibly incomparably disruptive." For many, the arrhythmia of fertility treatment came after a series of other disruptions, linked to things such as underlying health conditions. Fertility treatment was highly emotive and brought significant new demands—logistical, physical, and financial—informed by the governance regimes of clinic operations, treatment protocols, and national funding provisions. It was further complicated by being unpredictable, tied to bodily reactions:

> So that was nearly a month of doing all the jabs and just days and days of going in … bloods taken and ultrasounds done. And just the decision, "They're not doing very well. Oh no, let's keep going" … "Have you got enough drugs? No, you haven't got enough drugs. But I tell you what, we'll let you know what the outcome is this evening when your blood has come through, and then you can get the drugs tomorrow."
>
> (Lindsay)

Gabby explains how she was required to "do two complete cycles back-to-back" during her journey, due to their being only one follicle in the first round, and the specifics of NHS funding rules.

Participant accounts show complex relations between agency, surrendering to the rhythms imposed by treatments, and chance. One the one hand, engagement with fertility treatment was a decision, and there was significant action involved in researching underlying health issues, treatment, and/or clinic options. Several participant's referenced "fighting" for the right treatment or for funded care. On the other hand, participants felt swept along by the instructions of clinics and broader fertility industry communications (see Cervi and Brewis 2022) and were aware of the "luck" aspect to successful outcomes: "you can't really control an already uncontrollable situation" (Bhavna). This chimes with Cunningham and Cunningham (2013) who reported perceptions of loss of control in fertility treatment patients, as well as difficulties managing demanding treatment protocols.

Lefebvre's (2004) "dressage" came through strongly, with participants bending their bodies to the temporal, spatial, and physical demands of treatment adherence. Donna recalled watching "videos online" to supplement nurse explanations of injection self-administration, and feeling like the responsibility was on her to "figure it out." Carol spoke of programming an app on her phone for injection timings, adding: "I would just do what it told me"—alluding to an "alienation" (Lefebvre 2004) from the unconscious natural circadian rhythms of the body. There was also intense bodily monitoring and adherence to lifestyle advice said to maximize chances of treatment success, both from clinics and online sources: "I kind of researched it, what I should and shouldn't be doing and all of that" (Bhavna). Individuals talked about scheduling sex, diet modification, and alternative therapies, as well as surrendering to very invasive procedures.

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A notable and recurring pressure was the avoidance of stress—as stress might negatively impact chances of success—which was difficult when fertility treatment engagement was so new, so strict, so important, and so disruptive. When Donna recounted her "little routine" for self-administering medication, she concluded with: "I try to do all this as calmly as I can, because getting stressed about it doesn't help." Pippa also commented on "disappointments every month," adding:

> I kind of tried not to let that get on top of me too much, because then I was thinking, oh, I don't then want that to affect our chances. So, you kind of try and quash that, and then there's all the advice you read is just, just to relax!
>
> (Pippa)

Bhavna commented on the difficulties of keeping emotions and stress in check when you are "pumped full of hormones", and Carol mentioned the constant "pressure to do things quickly, because of … age," and the "biological clock." These themes were evident in the broader dataset.

As well as representing a significant arrhythmia in itself, the new rhythms of fertility treatment engagement posed myriad conflicts at the work–life interface. Logistical (temporal and spatial) conflicts came from clinic appointments and sensitive phone calls landing during the working day, and medication which needed to be stored and/or administered in the workplace. This arrhythmia impacted all participants, even those in relatively flexible and autonomous jobs, due to nested rhythms. For example, unpredictable appointments could clash with more fixed activities (i.e., teaching) within a generally flexible schedule; or make it hard for individuals to schedule certain activities. Gabby's research for example, involved medical interventions on animals, with each experiment comprising "about 6–8 weeks of very intense hands-on work." She added she would not be able to start an experiment if she knew she had to do a treatment cycle, which proved difficult. Una referenced the changing HE landscape, in terms of diversification of education programs and erosion of quieter times where treatment would be easier to manage (as noted by Ylijoki 2011; Berg and Seeber 2016):

> It wasn't like a normal academic cycle, there was the main course that happened, the September to the June, but then there'd be summer courses as well, there was never any down time.

Participants identified certain career stages or work contexts that felt especially incompatible with fertility activities. These included doctoral study, temporary (including overseas) contracts, potential redundancy situations, certain points in the REF cycle, and when seeking promotion. In these situations, it was the pressure and/or insecurity inherent in the role, career stage, or HE employment more generally that was considered problematic. Precarious contracts also brought a different type of work–life conflict, in the form of immediate and more long-term financial concerns. Maria honored a casual teaching commitment that clashed with her partner's clinic appointment because they needed the money for treatment, and she also did not want to "burn bridges" with a potential employer, thus compromising future financial security.

The arrhythmia brought about by clinic attendance and phone calls also carried another dimension—linked to the clash between the private and the public. Time away from work and taking personal calls in the office were deemed unprofessional, but fertility treatment was also something intensely private that individuals did not want recognized or overheard. There was therefore additional disciplining of the body and strategizing to avoid people knowing. Donna explained that some of her clinic appointments would be on a first-come first-served basis, so patients would line up ahead of the clinic opening at 8 a.m., in order to be treated and get to work before 9 a.m. She also thought intensely about how to navigate clinic calls:

> I certainly did not want anybody at my job to know that this was happening for me. So I would kind of try to figure out when in my day can I make this really sensitive telephone call, do I need to go sit in my car, how long can I do this, what if they call me and I have to pick up, but I can't pick up because I know there's somebody in the office next to me and they can hear me? It, I had this real sense of, I guess urgency about protecting my privacy, and … you know it was really intrusive into my work day.
>
> (Donna)

The unpredictable and emotive nature of clinic communications also meant that bodily reactions to news might betray the careful "dressage" of conforming to masculine workplace norms (Acker 1990). This brings us to a broader theme of embodied arrhythmia/work–life conflict that was evident in accounts. A range of emotional, cognitive, and physical reactions to treatment were cited, which felt problematic at work. Bhavna notes the effort required to avoid an emotional outburst at work:

> you work harder to kind of, you know, so no-one comes near you, because if anyone did kind of go "are you OK?", the chances of you bursting into tears were so much higher!… It's still very frowned upon if you burst into tears in front of the office … especially as I say when I was in an office full of fellas.

Gabby raised the issue of cognitive function and short-term memory, which was significantly affected by fertility drugs and her double-cycle. More generally cited was the impact of fertility treatment on ability to concentrate—because it "just absorbs so much of your mental mindscape" (Bhvana). This was an uncomfortable feeling, which Lindsay equated to "being out of control."

Although working at home was seen a good resource for helping conceal embodied reactions, certain HE roles and tasks were deemed especially difficult. These included teaching, where, as Pippa notes: "you're on show quite a lot to the students, so you've got to be on form"; dealing with pastoral issues, which could be emotive; dealing with difficult colleagues; focused

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academic writing—something core to academic performance expectations (Miller et al. 2011)—and academic conferences. As Gabby notes: "obviously … you don't want to say in front of a conference, I can't remember this because of the fertility drugs I'm taking."

Workplace factors could also impact on the body, showing a bidirectional conflict. For Catherine, who worked in a laboratory setting, there were concerns about exposure to certain substances or radiation. A significant concern—linking back to fertility industry messaging about risk and self-care (Cervi and Brewis 2022)—was concern about the impact of occupational stress. Pippa raised this in relation to both menstrual cycle disruption, which would then impact fertility treatment scheduling, and also on the likelihood of treatment success.

In fact, stress was a recurring—and stressful—issue for participants. Participants were stressed from the fertility treatment, often from the nature of their work, and from the juggle—of navigating this multifaceted arrhythmia:

> I found the two things feed very constantly into each other, and it's very difficult to say the infertility's stressing me this much and work is stressing me this much, because they're, I suppose they're so fundamentally part of me.
>
> (Gabby)

Therefore, arrhythmia was seen to be physical, spatial, financial, and embodied. A further dimension to arrhythmia concerned participant temporal orientations. It was not only experienced work–life conflict which informed thinking and action but also the anticipation of future arrhythmia, and navigating the impact of an accumulation of work–life conflicts over time—whereby short-term disruption was considered somewhat tolerable but became increasingly problematic (i.e., over multiple treatment rounds). This was also felt to be increasingly stressful. We explain these further in the next section, where we turn to participant responses to arrhythmia, which were temporally informed (Toyoki et al. 2006).

3.2 | Sense-Making, Work–Life Dilemmas, Response Strategies, and Consequences

Throughout the accounts, there was evidence of individualization of responsibility for navigating conflicting rhythms, and yet also a feeling of constrained agency, risk, powerlessness, and doubt. We identified several strategies that participants employed and presented here in rough chronological order to account for how they appeared in narratives.

Something often seen toward the start of narrated journeys, or when work rhythms were especially intense or unpredictable was "sequencing." This was a response to anticipated arrhythmia (involving projective agency) and involved delaying fertility activities—either starting fertility treatment or a particular cycle—to a future time, when they expected the impact on work/career to reduce. Lisa decided to wait until after her PhD viva to start treatment. This echoes findings of motherhood delay in early career female academics (i.e., Utoft 2020; Ollilainen 2020). Others paused fertility journeys until their work situation felt more stable (Lana and Jasmine), they were through the latest REF cycle (Lauren), or they had gained a promotion (Rachel). This could be a risky strategy in terms of fertility access and success (HFEA 2021), with most participants being acutely aware of—and concerned about—the "biological clock." It could therefore increase reproductive precarity. There were also several examples of postponing career progression or career-enhancing opportunities, which were perceived to bring more demanding work rhythms and hence more conflict with fertility and/or maternity:

> What I'd done quite a lot of was postpone decision-making. Because I was like, well you know, what if it works, what if it works? … I would've thought "oh no I can't do that" (opportunity) because there was a possibility that I might get pregnant.
>
> (Carol)

Unlike some care demands of motherhood, the embodied nature of fertility treatment meant that individuals could not delegate fertility activities to partners/other family members (as per Huopalainen and Satama 2019; Huppatz et al. 2019). Where arrhythmia was experienced, a range of individual strategies were employed by participants to attempt to resolve conflicts (practical-evaluative agency). Many individuals initially sought to maintain the public–private divide between the two rhythms. They engaged strategies which we term "subtly shifting tasks" and "fudging." Subtly shifting tasks involved quietly adjusting work tasks to mitigate logistical or bodily conflicts, without needing to disclose fertility treatment in the workplace. Participants spoke of attempting to (re)schedule activities according to their availability or fluctuating capacity:

> I would make sure that I saw the difficult people [direct reports] in the periods of time where I thought that I would probably be in a better place … on [pregnancy test] results day I would probably not put anything in my diary … I'd try and decrease the difficult stuff, and do some more sort of, I don't know, there was a lot of marking … you can kind of hide behind a lot of that.
>
> (Carol)

Catherine, concerned about exposure to radiation from her laboratory work (embodied arrhythmia), took to reading data sheets for different activities to assess potential risk and selected jobs accordingly. She also avoiding being in the radiation area at certain points in her fertility cycle:

> After ovulation I was, "Oh no I'm busy …" So I was booking myself into departmental seminars left, right and centre to give me excuses to not be in the lab.

Where fertility demands clashed with work commitments that could not be subtly shifted, many individuals reported taking time off work without stating the real reason—generic sick leave or citing "medical appointments"—which we term *fudging*.

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The first course of action added work to an already labor-intensive fertility journey, both strategies added stress and both could lead to negative consequences—in terms of professional image or career outcomes. Catherine was aware that her actions in avoiding the lab and certain tasks clashed with team norms and her manager's expectations and was concerned this might prove detrimental to advancement. She referenced a “general rebuke in one of the group meetings that we're supposed to work on things in the order they come in,” which she felt was aimed at her. She also felt bad for essentially lying to colleagues and her manager, something echoed by others. Although time off for medical appointments and sick leave were established governance regimes in the workplace, they were not ideal with fertility treatment, or indeed as a long-term strategy. Una cited generic medical appointments, but that she “had to keep canceling and reorganizing” adding “I just thought, oh god, my manager is going to get suspicious, why am I being so flaky?”. The cumulative impact of her absences also led to formal attendance management:

> I had to have a return-to-work conversation with my manager, her manager and an HR business partner … It was more around how my absences have impacted the team and I could only have X amount of days off within the next X amount of months.

Such strategies could therefore increase precarity, or feelings of not being safe, in several dimensions—bodily (through increased stress), relationally, and contractually (and thus financially).

In addition, subtly shifting tasks might only address certain facets of arrhythmia. Gabby's strategy of avoiding planning an experiment during the active treatment phase (blood tests and embryo transfer)—to reduce temporal and spatial arrhythmia—meant that the lab work began during the “2-week wait period,” and that “on the day that I found out that I was not pregnant, I had to go into work”—increasing bodily arrhythmia and demands for emotion management.

The next practical-evaluative strategy concerned “disclosure and help-seeking.” This violated the private–public divide and was felt to bring extreme vulnerability. It was often cited as coming later in participant journeys—often when the cumulative impact of arrhythmia was mounting and/or the participant felt that workplace performance or attendance expectations were being compromised. Lana explains feeling nervous about disclosing to her manager:

> So, in the end I did tell him … I was really nervous … because I just had no clue how he would respond.

Nerves were sadly often justified. In the absence of specific fertility-treatment policies in most of the participant's organizations, responses to disclosure were often lacking. Several participants reported manager and/or HR department confusion about time off recording, or being told to use annual leave. Others were subject to detrimental treatment. Stella (hourly paid teaching role) noted how her manager equated time off for fertility treatment to her “choosing to do something other than teach.” This manager, who was also her PhD supervisor—compounding her vulnerable positioning—then withdrew teaching hours. Other participants mentioned instances where they felt discriminated against, often connected to not being given new opportunities, because of treatment. Both nondisclosure and disclosure-based strategies could therefore result in increased employment precarity—either contractually or more implicitly (see Alberti et al. 2018), through increased experiential insecurity.

Although some participants did receive informal support and accommodations in response to fertility treatment disclosure, there was a sense that these were “fragile synchronicities” (Neis et al. 2018), which could falter at any time. Lana said her manager was initially supportive, but became less tolerant of canceled meetings and her reluctance to travel after multiple rounds of treatment, hinting at a reducing “balance sheet of credits on which adjustment relies” (Rouse et al. 2021, 724). Participants also worried that negotiated solutions might be compromised should their manager change or they move to a new role—common for those on temporary contracts. Gabby and Una both aired concerns about a forthcoming job change and their lack of relational capital:

> The whole time I've been kind of sailing on the goodwill of my boss … [and] I've no idea how to broach this with my new job.
>
> (Gabby)

> I'm not sure how I'll handle it in a new job, because I … obviously won't have years of goodwill that I've built up in this job.
>
> (Una)

This note of vulnerability permeated many accounts. The act of disclosure and/or ongoing need for support could make relationships with managers and colleagues more precarious, relating to Ivancheva et al.'s (2019) work on relational and affective insecurities, but here in the work domain.

Participants explicitly referenced legislative governance regimes that provide provisions and “protection” for other identities/experiences that they deemed comparable, such as provisions for disability, maternity, and adoption-related leave. In relation to the latter, Una commented on the added embodied element of fertility, and her incredulity that comparative support was not offered:

> I just felt that when actually it's something physical and it's drugs and it's an operation, that surely that should equate to at least the same amount of time off if not more.

Carol explained how the lack of policy further individualized the responsibility for managing arrhythmia:

> It makes it our choice and the consequences are our own, whereas for any other, for any other medical intervention it, it would be, you would get support from your institution.

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A final strategy that participants cited was another form of projective agency, concerning fundamentally changing the rhythms of employment and often effectively *downsizing their careers*. This strategy often came once other strategies had faltered—aimed at enabling more time and energy to be devoted to the fertility journey and/or because an individual felt too much damage had been done to their career—often their publication record, in a "publish or perish" (Miller et al. 2011) context. Within this small sub-sample, six participants either reduced their hours, changed jobs, or left (at least temporarily) the workplace. Felicity relinquished a "permanent pensionable job" to take a precarious short-term part-time position because she felt she "couldn't spin all the plates" required in the former. She added: "I've sort of stepped off the academic trajectory, I'm more sort of managing research now rather than doing research."

Gabby noted the lack of any consideration for past arrhythmia in recruitment, funding and progression processes. She felt she had no choice but to step off the research-track and find an alternative role:

> [As a] postdoc trying to move into that lecturer/fellow position, [there is] no way to take account of any of it .... it's just kind of decimated my publication record ... and I can't really explain it, because on a fellowship application or a funding application, I've got 200 words to say why I'm the best person. And I can't really say in those 200 words, I'm the best scientist to do this, this is the best place to do it, oh and by the way my publication record is crap because I've spent four years doing repeated lines of fertility treatment.

She added:

> I'm one of that generation who were raised, like, you can have anything you want if you just work hard enough ... if you fight hard enough ... And, I suppose over these last few years I've found that that's not actually true. And, you have to make sacrifices, and you have to constantly decide what are you fighting hardest for ... it's not that I haven't fought for my career, but I think when push comes to shove ... if we review how I've spent my time in the last 5 years, I've fought hardest to have a baby. And what that has meant is that I don't really have an academic career. I have a career, because I have a new job, but it's a different kind of career than I thought ... I always thought I'm a good academic.

We characterize such transitions as "career downsizing" because these individuals are having to reframe what they expect from their careers in the light of fertility journey disruption. This (alongside discrimination) helps understand some of the negative career impacts linked to fertility treatment noted in different contexts (i.e., Ichikawa et al. 2020; Imai et al. 2021).

Throughout the dataset, participants frequently used words like "gambling," "risking," "uncertainty," "worry," "sacrificing," and feeling "guilty." We offer the concept "work–life fragility" to account for the complex work–life interface illustrated in participant narratives, whereby (1) two unstable and precarious rhythms intersect, creating multifaceted arrhythmia, (2) there is an individualization of responsibility to address arrhythmia (linked to the public–private divide, concerns about stigma and legitimacy, and an absence of robust governance regimes to prevent or mitigate the impact of arrhythmia), and (3) individual strategies provide only "fragile synchronicities" (Neis et al. 2018) due to fallible resources, which can amplify feelings of insecurity. As this positioning is not sustainable, individuals often ultimately compromise (professional) goals in the longer term.

4 | Conclusions and Implications

Our use of rhythmanalysis to explore the experience of (mainly) women navigating fertility treatment alongside employment in higher education reveals a complex interplay between agency, conformity, and constraint. First with regards to engaging with fertility treatment itself—which amounts to a type of arrhythmia in participant everyday lives—then in managing the demands of this complex, unpredictable and intensely private process alongside the public rhythms of employment. In response to multifaceted arrhythmia, with limited resources, participants were shown to engage in projective and practical-evaluative agency aimed at adhering to (Lefebvre's "dressage") and preserving (as per Toyoki et al. 2006) the rhythms of both treatment and employment as much as possible. This proved emotional, stressful, and exhausting—states that are at odds with the expectations of each institution. There was a huge sense of personal responsibility in accounts, alongside a feeling of lack of control/powerlessness—meaning risk and guilt dominate, and precarity (across dimensions of employment, relationships, and the body) could be compounded by individual decisions and actions. Although Toyoki et al. (2006, 110) talk about the power of agency to "negotiate and construct ontological security," our participants seem to be in a position of gendered ontological insecurity for much of their journeys.

Our paper contributes to work–life interface scholarship by providing a rich empirical account of an under-studied "life" domain phenomenon (fertility treatment instead of mothering/parenting). We believe that Lefebvre's (2004) *Rhythmanalysis*, and especially when supplemented by key concepts from Toyoki et al. (2006), provides a useful toolkit for work–life scholars for developing theorization—bringing the body more explicitly into theorizing, foregrounding power dynamics, and acknowledging both short- and longer-term concerns and the dilemmas that can ensue. In this paper we offer the concept of "work–life fragility" to show the recursive relationship between precarity, arrhythmia, and constrained agency at this specific work–life interface; where myriad forms of conflict exist, and individuals are faced with complex work–life dilemmas (Wilkinson et al. 2017). We extend the dilemmas concept by acknowledging the added discomfort where outcomes in both domains are unpredictable and uncontrollable—where time and

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energy investments will not necessarily lead to positive outcomes, and so actions feel like "gambling." Our approach to the phenomenon—using biographical narrative interviews and rhythmanalysis—proved helpful for illuminating the small step-by-step moments of lived experience fragility at the work–life interface that may contribute to unequal outcomes and psychological distress but may be hard to spot using different analytic techniques.

We focus the analysis on HE as an illustrative case, as universities are "greedy institutions" (Bone et al. 2018) where workers invest substantial time and energy and yet are afforded limited security. This then matches the "all consuming" nature of fertility treatment engagement and "greedy institutions" of the fertility industry (Cervi and Brewis 2022), and yet the limited rates of fertility treatment success. However, it is important to acknowledge that HE is not the most precarious employment context, and that many workers in other sectors have far fewer resources and employment protections. It is notable that very few participants in the broader dataset were in extremely precarious employment, such as zero-hours and front-line roles in hospitality or delivery work—which disproportionately impact women (i.e., Dingeldey and Gerlitz 2022), and where women *perceive* greater insecurity (Menéndez-Espina et al. 2020). Few such workers perhaps feel able to engage with fertility treatment in the first place (see Wilkinson et al. 2023). Indeed, the fact that we had so many volunteers from HE could be because academic employment offers some of the features, at least some of the time, that allow fertility treatment to be contemplated (i.e., decent pay, sick leave provisions, flexibility).

The practical implications of our arguments concern extending government and employer consideration of workplace support for fertility treatment beyond the issue of (paid) time off for appointments—which is the dominant narrative and connected to a more narrow work–life interface conceptualization—to fully address the complexity of the embodied phenomenon and shift the responsibility for mitigating arrhythmia off the shoulders of individual staff. We argue for the need for adequate psychosocial risk assessments for those undergoing fertility treatment (as currently legislated in the UK around pregnancy/maternity), mental health provisions, interventions aimed at helping individuals work through the different dilemmas (i.e., coaching), and peer support mechanisms that make this feel less of a private issue to navigate alone. We also suggest that the significant (and cumulative) impact of fertility treatment should be acknowledged at every stage of the employee life-cycle to help mitigate potential career impacts. This implicates systems-thinking to include absence management processes, as well as recruitment, probation, performance, and promotion/career development processes. There should also be adequate learning and development provisions for line managers as key stakeholders—to develop their rhythm intelligence (Rouse et al. 2021), as in their capability and commitment to recognize work–life conflicts and co-create solutions with affected staff. Provisions should cover all workers, not just employees.

We urge other work–life scholars to consider the utility of rhythmanalysis for work–life interface theorizing. Future research could also explore the utility of the "work–life fragility" concept for understanding the impact of fertility treatment on workers in different national and occupational contexts, and indeed the interaction of other unstable, private, and/or embodied nonwork experiences (such as fluctuating health conditions or complex care commitments) with precarious employment contexts, and the emotional impact of navigating work–life dilemmas. Research is also needed to trial and evaluate policy and practice provisions to identify which have the most beneficial effect for differently positioned workers.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Endnotes

[1] The Research Excellent Framework is the UK's system for assessing research quality in UK HE providers, the outcomes of which inform the allocation of public funding. Submissions are required roughly every 7 years https://www.ref.ac.uk/about/what-is-the-ref/.

[2] This could be connected to our recruitment strategy, which included a Facebook group for academic women as well as other channels.

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