

GENDER INEQUALITY IN IN VITRO FERTILIZATION: CONTROLLING WOMEN'S REPRODUCTIVE AUTONOMY

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I. INTRODUCTION

This Note¹ attempts to add to those voices currently critiquing the new reproductive technologies by suggesting a two-step analysis which (1) analyzes how a specific reproductive technology can create inequitable power structures for women who turn to it, and (2) places that reproductive technology within a larger pattern of controlling all women's reproductive autonomy. While step one may be a familiar one to writers critiquing reproductive technologies, step two—taking the analysis, placing it as part of a larger pattern of control, and then reevaluating the analysis—may be a newer but necessary approach. Placing the reproductive technology within a larger pattern of control is necessary since simply critiquing the inequality within a reproductive technique cannot provide a full picture of the extent and type of control exhibited over women's reproductive autonomy. It also cannot provide the opportunity to investigate how the analysis itself changes once one steps back from the specific focus—a single reproductive technology—and views a larger entity—all women's reproductive autonomy.

This Note will apply this two-part analysis to the specific reproductive technology of in vitro fertilization (IVF). IVF is the process whereby a woman's egg is fertilized with sperm in a petri dish and then returned to the woman's uterus for development and delivery.² This Note argues that IVF has not received the close scrutiny necessary to prevent its potential misuse against the women turning to the technology. This Note will analyze the power structure within IVF by looking at the power relations between the women and the technology, the women and the doctors, and the phenomena of informed consent.

The question will then be asked: "Who is missing from IVF

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² Tanya Feliciano, Note, *Davis v. Davis: What About Future Disputes?*, 26 CONN. L. REV. 305, 307-08 (1993).

participation and why?" Research from a variety of areas suggests that IVF is employed by a relatively select subgroup of women in the United States (white, middle-/upper-class, heterosexual couples). While having a technology that is used only by selected women suggests inequality, questioning why this occurs will shed light on how reproductive technologies can be used to impact on all women's reproductive autonomy.

Part two of the analysis places the inequality within IVF into the larger pattern of societal control over women's reproductive autonomy. There are many ways this can be accomplished. This Note argues that control over women's reproductive autonomy is demonstrated by the selective valorization of some women's reproductivity and the selective devalorization of other women's reproductivity. By viewing IVF alongside such reproductive controls as forced sterilization, Norplant®³ use as a condition of probation, and fetal abuse laws, a larger pattern becomes clear which may not be seen when each phenomenon is viewed individually. Some women are being pushed toward reproduction as a result of the reproductive options available to them while other women are pushed away from reproduction as a result of the choices open to them.

Using an analysis which questions not only the inequality within the reproductive technology but also the inequality in the application of all reproductive technologies allows for the identification of larger patterns of control not visible through an individual analysis approach. It is only through this questioning of the development and use of reproductive technologies that women can gain control over the technologies and truly use them on their own terms and for the benefit of all women.

II. IVF: A MEDICAL TECHNIQUE

The first baby conceived through the use of IVF was born in England in 1978.⁴ The first baby born in the United States through the use of IVF came three years later in Virginia.⁵ These births, however, followed years of medical development, including a 1973 procedure in which an egg was fertilized in vitro, allowed to

³ The Norplant System® is marketed in the United States by Wyeth-Averst Laboratories, Inc. of Philadelphia, Pennsylvania. PHYSICIANS' DESK REFERENCE 3085 (1998) [hereinafter, Norplant].

⁴ George J. Annas & Sherman Elias, *In Vitro Fertilization and Embryo Transfer: Medicolegal Aspects of a New Technique to Create a Family*, 17 FAM. L.Q. 199, 202 (1983).

⁵ *Id.*

develop to the several-cell stage, and then transferred to a patient who underwent a hysterectomy two days later.⁶ By the mid-1980s, many no longer considered IVF an experimental procedure, and as of 1993 an estimated 700 IVF programs in over fifty-three countries were in operation.⁷

An IVF treatment, or cycle, can be divided into three phases: egg retrieval, fertilization and implantation, and storage.

A. Egg Retrieval

As part of the retrieval phase, clients are given a series of psychological and physical tests to screen and prepare for the procedure. Once screened, the woman is usually given drugs to produce superovulation (production of multiple eggs during one cycle).⁸ The procedure is monitored daily through blood hormonal assays and ultrasounds in order to track the quality and quantity of developing eggs.⁹ Once the maximum achievement point is reached, human chorionic gonadotropin (hCG) is given to the woman to achieve final maturation of the eggs.¹⁰

Thirty-four hours after the use of hCG, the eggs are gathered either through the use of a laparoscopy or a transvaginal ultrasound.¹¹ The 1992 IVF-ET Registry published by the Society for Assisted Reproductive Technologies (SART) reported that 85% of IVF stimulations (24,996 out of 29,404 cycles) lead to an egg retrieval.¹²

⁶ Melvin G. Dodson et al., *A Detailed Program Review of In Vitro Fertilization with a Discussion and Comparison of Alternative Approaches*, 162 SURGERY, GYNECOLOGY & OBSTETRICS 89, 90 (1986).

⁷ Marsden G. Wagner & Patricia Stephenson, *Infertility and In Vitro Fertilization: Is the Tail Wagging the Dog?*, in *TOUGH CHOICES: IN VITRO FERTILIZATION AND THE REPRODUCTIVE TECHNOLOGIES* 1, 2 (Patricia Stephenson & Marsden G. Wagner eds., 1993).

⁸ Alan O. Trounson & Carl Wood, *IVF and Related Technology: The Present and the Future*, 158 MED. J. OF AUSTR. 853, 854 (1993).

⁹ Jean Macchiaroli Eggen, *The "Orwellian Nightmare" Reconsidered: A Proposed Regulatory Framework for the Advanced Reproductive Technologies*, 25 GA. L. REV. 625, 633 (1991).

¹⁰ *Id.*

¹¹ *Id.* at 633-34. With a laparoscopy, a needle is inserted through the woman's abdomen and gentle suction is used to retrieve the eggs. Feliciano, *supra* note 2, at 307. A transvaginal ultrasound locates structures by measuring reflections of high frequency waves, and does not require anesthesia. Feliciano, *supra* note 2, at 307; STEDMAN'S MEDICAL DICTIONARY 1883 (26th ed. 1995).

¹² *Assisted Reproductive Technology in the United States and Canada: 1992 Results Generated from The American Fertility Society / Society for Assisted Reproductive Technology Registry*, 62 FERTILITY & STERILITY 1121, 1123 tbl. 1 (1994) [hereinafter 1992 IVF-ET Registry Report]. An alternative to having the recipient produce her own eggs is to use one provided by a donor.

B. Fertilization and Implantation

Once eggs are obtained they are placed with sperm in a petri dish containing a special medium and allowed to fertilize and grow to the four-cell stage.¹³ At this point, the embryos are ready for transfer into the recipient's uterus.¹⁴ This is done with the use of a catheter inserted through the woman's cervix and into her uterus.¹⁵ The number of embryos transplanted is usually balanced with evidence that as the number of embryos transferred increases, so does the pregnancy rate.¹⁶

If transfer is successful, the embryos will attach to the uterine wall and continue as if a natural conception had occurred.¹⁷ Throughout the woman's first trimester, she is given estrogen and progesterone replacement therapy to help maintain the pregnancy.¹⁸ The woman, if given drugs to increase ovulation, is also given a series of drugs to return her cycle to normal.¹⁹

C. Storage

If superovulation has produced a high number of eggs for which implantation at one time is unwarranted or unwanted, a technique is used which allows doctors to freeze the "extra" embryos for later implantation.²⁰ Called cryopreservation, this technique has proven instrumental in the field. In cryopreservation, embryos are placed in vials containing a freezing medium and a

¹³ James M. Treppa, *In Vitro Fertilization Through Egg Donation: A Prospective View of Legal Issues*, 22 GOLDEN GATE U. L. REV. 777, 781 (1992).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ The 1989 IVF-ET Registry reported that clinical pregnancy rates and corresponding live delivery rates among reporting fertility clinics were 15% and 13% respectively for transfers of less than three embryos, 21% and 16% respectively for transfer of three embryos, and 25% and 18% respectively for transfer of four or more embryos. *In Vitro Fertilization-Embryo Transfer (IVF-ET) in the United States: 1989 Results from the IVF-ET Registry*, 55 FERTILITY & STERILITY 14, 16 (1991) [hereinafter 1989 IVF-ET Registry Report]. The Society for Assisted Reproductive Technology (SART), part of The American Fertility Society (AFS) and Medical Research International (MRI), was established to "explore the epidemiology of the [assisted reproductive technologies]." *Id.* at 14.

¹⁷ Treppa, *supra* note 13, at 781.

¹⁸ Treppa, *supra* note 13, at 781 n.27 (citing Mark V. Sauer et al., *A Preliminary Report on Oocyte Donation Extending Reproductive Potential to Women over 40*, 323 NEW ENG. J. MED. 1157, 1158 (1990)).

¹⁹ Katheryn D. Katz, *Ghost Mothers: Human Egg Donation and the Legacy of the Past*, 57 ALB. L. REV. 733, 773 (1994).

²⁰ Eggen, *supra* note 9, at 638.

cryoprotective agent.²¹ The temperature of the vials are then lowered from 22° C (room temperature) to -80° C.²² The frozen vials are then placed in liquid nitrogen at a temperature of -196° C.²³ At this temperature, biological activity is not considered possible.²⁴ Embryos are typically frozen at the 2-, 4-, or 8-cell stage since earlier or later embryos are too difficult to freeze or do not develop normally once thawed.²⁵

Cryopreservation lowers the risk of multiple births by allowing only one or two embryos to be implanted at one time and the others preserved for later use.²⁶ Freezing the unused embryos also saves a woman from having to repeat the ovulation and egg collection process, thereby saving her body from additional drug therapy and controlling costs of the procedure with each implantation.²⁷ Cryopreservation is also useful in cases where there is some complication during the stimulation cycle or where patients will be undergoing medical therapy that will cause sterility (i.e., for leukemia or breast cancer).²⁸ Alternatively, cryopreservation might be used when a woman undergoes sterilization and wishes to store any eggs available at the time of surgery for possible later use.²⁹ Proponents note that once cryopreservation has been perfected, women will be able to store unfertilized eggs in much the same way men are currently able to freeze their sperm.³⁰

In 1989, the IVF-ET SART Registry reported the transfer of 2,124 cryopreserved embryos by 110 reporting clinics. Ten of these clinics accounted for 56% of the total clinical pregnancy rate (11%) and 54% of the overall live delivery rate (8%).³¹ In general, an 8-12% increase in IVF pregnancies occurs by using cryopreservation.³² This may be attributable to psychological and physical benefits cryopreservation offers women undergoing IVF.

²¹ Phyllis L. Bean, Comment, *Taking the Frozen Embryo to Court in Virginia: A Proposed Statute*, 13 GEO. MASON L. REV. 127, 130 (1990).

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ Colleen M. Browne & Brian J. Hynes, Note, *The Legal Status of Frozen Embryos: Analysis and Proposed Guidelines for a Uniform Law*, 17 J. OF LEGIS. 97, 99 (1990).

²⁶ See Eggen, *supra* note 9, at 638.

²⁷ See Treppa, *supra* note 13, at 781.

²⁸ Trounson & Wood, *supra* note 8, at 855.

²⁹ Eggen, *supra* note 9, at 640 n.53.

³⁰ Katz, *supra* note 19, at 771.

³¹ 1989 IVF-ET Registry Report, *supra* note 16, at 20.

³² Treppa, *supra* note 13, at 781.

III. IVF AS A TOOL OF GENDER INEQUALITY

As noted earlier, this note argues IVF can create inequitable power structures for the women who turn to it. This can occur through the power dynamic involved in using IVF as well as through the selective control over who has access to the technology. This section discusses IVF's potential misuse by: 1) analyzing the power structure within IVF which minimizes women's control, and 2) discussing the select demographics of IVF users.

The power relationship within IVF takes various forms. The relationships between the women and the technology, the women as patients and their doctors, and the concept of informed consent, are all examples of how IVF creates inequitable power structures for women and will be discussed below.

A. *Women v. Technology*

Women using IVF turn to the technology because they are told the technology can overcome a defect of their own bodies—infertility. When they turn to IVF women place their control over their bodies into the hands of the technology. But is this necessary? Women's relationship with the technology, built on a belief that the technology can grant fertility, may be based on unreasonable definitions of infertility. If so, women may be turning to IVF too soon and in so doing unnecessarily cede power over their person to the technology.

The United States Office of Technology Assessment (OTA) defines infertility as the inability to conceive after one year of intercourse without contraception.³³ Critics such as Janice Raymond point out that this definition does not take into consideration couples who already have children who only recently became "infertile."³⁴ Noting that the time requirement of the OTA definition of infertility has decreased within the past decade to its current one year requirement, Raymond questions the appropriateness of such a time frame since older women and those previously on birth control can sometimes experience temporary infertility.³⁵ If women

³³ Wagner & Stephenson, *supra* note 7, at 3. Not all agencies, however, use such a lenient definition of infertility. The World Health Organization (WHO) requires a two year inability to conceive to meet the definition of infertility. Wagner & Stephenson, *supra* note 7, at 3.

³⁴ JANICE G. RAYMOND, *WOMEN AS WOMBS: REPRODUCTIVE TECHNOLOGIES AND THE BATTLE OVER WOMEN'S FREEDOM* 5 (1993).

³⁵ *Id.* at 3.

are turning to IVF too soon, they are exposing themselves to unnecessary physical, psychological, and financial burdens.

Critics such as Wagner and Stephenson argue that the one year period is misleading. They point to one study which suggested only 16% to 21% of couples originally meeting this one year definition of infertility remained infertile throughout their lives.³⁶ Further, they argue that the definition does not take into consideration the frequency of intercourse. One study reported that "16.7% of couples having intercourse less than once a week conceived within [six] months, but 83.3% of couples having intercourse four or more times a week conceived within that same period."³⁷

Ruth Hubbard has also suggested that this time requirement is inadequate.³⁸ She cites a 1983 study which found that over a two to seven year period, 41% of couples undergoing fertility treatments became pregnant, as did 35% of those couples who did not pursue the fertility treatments.³⁹ Indeed, Wagner and Stephenson suggest infertility "has become a kind of new morbidity—a medical reconstruction of a social problem, that is, involuntary childlessness."⁴⁰

IVF and infertility treatments have also been criticized as not being true aids to infertile women as the goal is not to correct infertility, but only to bypass it. One study comparing IVF pregnancy rates versus surgery procedures designed to repair the damaged reproductive systems, found a continuing pregnancy rate of 25% to 30% with microsurgery or laser surgery using a laparoscope to repair damaged fallopian tubes, a continuing pregnancy rate of 21% to 41% for procedures with carbon-dioxide lasers in "fertility-promoting procedures," and a 30% to 70% continuing pregnancy rate for a "laser applied through a laparoscope, either alone or in conjunction with danazol"⁴¹ This is compared to a continuing pregnancy rate with IVF of 10%, plus the need for repeat procedures with each pregnancy the woman desires.⁴² In response, groups such as the Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE), argue that

³⁶ Wagner & Stephenson, *supra* note 7, at 3.

³⁷ Wagner & Stephenson, *supra* note 7, at 6.

³⁸ RUTH HUBBARD, *THE POLITICS OF WOMEN'S BIOLOGY* 203 (1990).

³⁹ *Id.* at 203.

⁴⁰ Wagner & Stephenson, *supra* note 7, at 2.

⁴¹ H. David Banta, *Technology Assessment and Infertility Care*, in *TOUGH CHOICES: IN VITRO FERTILIZATION AND THE REPRODUCTIVE TECHNOLOGIES* 53, 58-59 (Patricia Stephenson & Marsden G. Wagner eds., 1993).

⁴² *Id.* at 59.

the focus should be shifted away from the reproductive technology and instead placed on identifying the causes of infertility and researching prevention.⁴³

If, as these critics suggest, current definitions of infertility lead to over diagnosis of infertility, women may be turning to IVF who do not need to and in so doing placing themselves in unnecessary danger. The safety of clinics, for example, has been questioned. An outbreak of hepatitis which affected 172 women, was reported in one IVF program in The Netherlands.⁴⁴ The culture medium used to grow fertilized embryos was contaminated with hepatitis B virus.⁴⁵ This type of physical danger is in addition to the ceding of control of one's body to the technology.

B. Patient v. Doctor Relationship

As women coming to IVF clinics usually are emotionally and physically drained and often see IVF as their last chance to have biological offspring,⁴⁶ the patient/doctor relationship in IVF is potentially problematic. This relationship can cause women to become subjugated to a technology "owned" by the doctor. This ownership of IVF technology has the potential to minimize women's roles as women, mothers, and individuals, and to make women mere vessels in the process of childbirth. Indeed in many cases, IVF doctors are perceived as giving life where the women have failed. This dynamic can place extreme guilt and anxiety on women who see their compliance with IVF protocols as the only way to become pregnant. One study of 200 pre-treatment couples noted that 49% of women believed infertility to be the most upsetting experience of their lives.⁴⁷ This is compared to only 15% of the men interviewed.⁴⁸

Women lose autonomy over their reproductive identity when

⁴³ Susan Behuniak-Long, *Radical Conceptions: Reproductive Technologies and Feminist Theories*, 10 WOMEN & POLITICS 39, 51-52 (1990).

⁴⁴ Pat Spallone, *Reproductive Health and Reproductive Technology*, in WOMEN AND HEALTH: FEMINIST PERSPECTIVES 49, 58 (Sue Wilkinson & Celia Kitzinger eds., 1994).

⁴⁵ *Id.*

⁴⁶ Dorothy Greenfeld & Florence Haseltine, *Candidate Selection and Psychosocial Considerations of In-Vitro Fertilization Procedures*, 29 CLINICAL OBSTETRICS & GYNECOLOGY 119, 119 (1986) (reporting couples coming to IVF programs have long histories of infertility treatment including drug therapy and surgery).

⁴⁷ *Id.* at 123. See also Dorothy E. Roberts, *The Genetic Tie*, 62 U. CHI. L. REV. 209, 215 (1995) [hereinafter Roberts, *Genetic Tie*] ("[P]eople often see the inability to produce one's own children as one of nature's most tragic curses.").

⁴⁸ Greenfeld & Haseltine, *supra* note 46, at 123.

they begin IVF programs. Ann Oakley described the phenomena in this manner:

For a complex of reasons, then, reproduction exposes the social fragility of women, not as the weaker but as the *second sex*, to use Simone de Beauvoir's term. Women's existence as childbearers is subject to a central paradox: although the *most* socially important activity, it is also rendered the *least* important, as cultural ideologies and practices enforce women's marginalization.⁴⁹

Also note the relationship between Leslie Brown, the mother of the world's first IVF baby, and her doctors, Drs. Steptoe and Edwards. Her doctors insisted Brown not tell anyone about the procedure and had her sign an agreement consenting to an abortion if the doctors thought it necessary.⁵⁰ "Presumably [the doctors] did not want to have the entire venture discredited by letting the first baby be born with a disability."⁵¹ Again, women's interests and reproductive autonomy are subjugated to the larger goals of creating a technology and in the doctors controlling it.

C. *Informed v. Uninformed Consent*

Critics of IVF have charged that due to a lack of enforcement of informed consent or even a specific definition of what constitutes informed consent, women turning to IVF are placed in the position of ceding their control to a technology which many argue is still, despite the medical community's assurances to the contrary, experimental.⁵² These critics charge that no clinical trials, cost analysis, analysis of social consequences, or ethical discussions have been performed, and that IVF should remain an experimental procedure and be ruled by the "safeguards covering research on human subjects."⁵³ Questions such as these concerning the experimental nature of IVF make informed consent questionable.

Wagner and Stephenson also express concern over the ways pregnancy success rates are reported.⁵⁴ For example, they noted that women experienced disappointment when they found out that the 20-25% pregnancy rate reported by one clinic was misleading.⁵⁵

⁴⁹ ANN OAKLEY, *ESSAYS ON WOMEN, MEDICINE AND HEALTH* 99 (1993) (footnote omitted). Oakley is referring to the work *The Second Sex* by Simone de Beauvoir. See generally SIMONE DE BEAUVOIR, *THE SECOND SEX* (H.M. Parshley ed. & trans., Alfred A. Knopf, Inc. 1952) (1949).

⁵⁰ Hubbard, *supra* note 38, at 204.

⁵¹ Hubbard, *supra* note 38, at 204.

⁵² Wagner & Stephenson, *supra* note 7, at 1.

⁵³ Wagner & Stephenson, *supra* note 7, at 1.

⁵⁴ Wagner & Stephenson, *supra* note 7, at 17.

⁵⁵ Wagner & Stephenson, *supra* note 7, at 17.

In actuality, only 40% of women in that program reached the 20%-25% point.⁵⁶ Unfortunately this was information the women found out only *after* entering the program.⁵⁷ For women to make informed decisions about their participation in IVF programs, they need to have accurate and standardized information. However, the use of different pregnancy definitions can also mislead women.

Variations in reporting rates of pregnancy are attributed to different meanings given to pregnancy—clinical pregnancy versus pregnancy resulting in delivery. If a woman is pregnant for two days and then suffers a miscarriage, an IVF clinic may refer to this as a successful pregnancy and report it as such.⁵⁸ Women's goals are a "take-home" baby and not solely a pregnancy.⁵⁹ These rates are obviously very different. Compare the two compilations of the same facts presented below. The 1992 IVF-ET Registry reported that 29,404 IVF cycles were conducted in 1992 with the following break-down:

- 85% of cycles led to an egg retrieval (24,996)
- 87.5% of retrievals led to an embryo transfer (21,870)
- 24.1% of transfers led to a clinical pregnancy (5,279)
- 16.8% live delivery rate per retrieval (4,206)⁶⁰

Note these percentages are derived from the total number of cycles that led to an egg retrieval.

Now look at the information presented another way. Here, the total number of cycles becomes the reference point for each calculation, regardless of whether it led to an egg retrieval:

- 85% of all cycles led to an egg retrieval (24,996)
- 74.4% of all cycles led to an egg transfer (21,870)
- 18% of all cycles led to a clinical pregnancy (5,279)
- 14.3% of all cycles led to a live delivery (4,206)

The 14.3% live delivery rate may be of more value to women as it standardizes the reference point—cycles—as well as addresses women's association with each cycle with a birth. This is not to say that 14.3% (or one out of seven) of each woman's cycles will lead to a live birth. These figures do not include information on causes of infertility and, therefore, do not take into account women for whom IVF has a higher probability of success than those for whom

⁵⁶ Wagner & Stephenson, *supra* note 7, at 17.

⁵⁷ Wagner & Stephenson, *supra* note 7, at 17.

⁵⁸ Dr. Martha Field, *Reproductive Technologies and Surrogacy: Legal Issues*, 25 CREIGHTON L. REV. 1589, 1597 (1992).

⁵⁹ Wagner & Stephenson, *supra* note 7, at 8.

⁶⁰ 1992 IVF-ET Registry Report, *supra* note 12, at 1123 tbl. 1.

it does not.⁶¹ In part to remedy the discrepancy in expectations, Dr. Martha Field suggests women get counseling on the success rates, costs, psychological stress, and available alternatives before beginning an IVF program.⁶²

This lack of clear and accurate information hampers a woman's ability to give full and informed consent. But further, the severe emotional toll and anxiety women are under when they come to IVF clinics also impacts on a woman's ability to make informed decisions. Wagner and Stephenson indicated that it is necessary to investigate how IVF is marketed, how success rates are calculated, how they are communicated to patients, how hospitals sell the experimental procedures, and how physicians disclose the risks of IVF.⁶³

While this could be construed as a problem within the medical industry rather than one specific to women, two items are important to remember. First, in a society and industry which are defined by male standards, women are typically placed second. Second, those steps that have been taken to try and control the IVF industry have basically been geared to the needs of consumers, not women.

Informed consent is of imperative importance in a technology like IVF where women come to the technology desperate for a baby and often view IVF as their last chance.⁶⁴ Nancy Ehrenreich notes that "by ceding [the doctor] all control over her reproductive processes, [a woman] disempowers herself in a way likely to be deeply destructive of her sense of self."⁶⁵ These feelings were expressed by Mrs. J, a woman undergoing IVF treatments, in a 1986 publication of candidate selection:

It's like a steeplechase. One hurdle after another. First you worry that you won't be accepted in the program. After you are accepted, you worry about all that waiting and the enormous cost. Once you start the program, you worry that you might do something wrong or that you will not understand the instruction. Then you worry about getting the injections and the effects of the drugs that they give you. Then you worry that they will not get eggs. Or that the eggs won't fertilize. Finally, they do the implant and you are hit with what you feared all along—

⁶¹ 1992 IVF-ET Registry Report, *supra* note 12, at 1122-23.

⁶² Field, *supra* note 58, at 1597.

⁶³ Wagner & Stephenson, *supra* note 7, at 17.

⁶⁴ See Greenfeld & Haseltine, *supra* note 46, at 119 (suggesting long histories of surgery and drug therapy in couples entering IVF programs).

⁶⁵ Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 495 (1993).

that you won't get pregnant.⁶⁶

You might do something wrong and as a result you may not get pregnant. This relationship makes informed consent questionable.

Susan Bordo sums the effects of medical technologies on women's ability to choose by stating:

On the one hand, women now have a booming technology seemingly focused on fulfilling *their* desires: to conceive, to prevent miscarriage, to deliver a healthy baby at term. On the other hand, proponents and practitioners continually encourage women to treat their bodies as passive instruments of those goals, ready and willing, "if they want a child badly enough," to endure however complicated and invasive a regime of diagnostic testing, daily monitoring, injections, and operative procedures may be required.⁶⁷

One report noted that of ninety-one couples dropping out after one IVF attempt, fifty-five (60.4%) said anxiety was their reason for not continuing.⁶⁸

The anxiety to have a child and the concern that their actions might harm their chances, force women's identities to be sublimated to the technology, the doctor, and inaccurate definitions of informed consent. Women coming to IVF are placed in an interminable bind: they are told their bodies are incapable of producing offspring without aid (a misnomer as many couples are now undergoing IVF for male related infertility problems⁶⁹), that IVF is their last chance, and if no baby is produced it is due to a woman's non-compliance to a strict protocol (when in reality compliance does not guarantee a baby).

IV. THE DEMOGRAPHICS OF IVF USE

On one hand, we have a technology which says it offers women the possibility of having children they could not have before. On the other hand, we have the narrowing of the reproductive autonomy of the women turning to IVF. There is also another concern with IVF use—the demography of IVF users. Currently, a relatively select subgroup of United States society turns to IVF. Although the data on IVF users is sparse, available data suggest an unequal use of

⁶⁶ Greenfeld & Haseltine, *supra* note 46, at 123-24.

⁶⁷ SUSAN BORDO, *UNBEARABLE WEIGHT: FEMINISM, WESTERN CULTURE, AND THE BODY* 86 (1993).

⁶⁸ Greenfeld & Haseltine, *supra* note 46, at 124.

⁶⁹ Sharyn L. Roach Anleu, *Reproductive Autonomy and Reproductive Technology: Gender, Deviance and Infertility*, in *INTERSECTIONS: WOMEN ON LAW, MEDICINE AND TECHNOLOGY* 99, 105 (Kerry Petersen ed., 1997).

IVF by white, middle-/upper-class, married women. A brief discussion of the voices missing from IVF use and its ramifications are discussed below.

A. Poor Women

The cost of IVF has been estimated to be between \$67,000 and \$114,000.⁷⁰ This insures that most poor women cannot access fertility programs without outside help. But according to the Committee to Study Outreach for Prenatal Care, more than one-fourth of all "women of reproductive age . . . have no insurance to cover maternity care, and two-thirds of [this population of reproductive age] have no health insurance at all."⁷¹ For the uninsured, the costs of IVF can be prohibitive.⁷²

A "justification" for the exclusion of poor women from access to IVF services is based on a stereotypical association of poor women and children—that poor women have children to get more money from state assistance programs. Issues like sterilization and mandatory Norplant use are based on this perception⁷³—regardless of its validity. Society stereotypes poor women as having "too many children" which "we" have to support. With this mindset, it is unlikely that mechanisms will be established which would aid infertile poor women in accessing IVF,⁷⁴ and indeed as will be suggested

⁷⁰ Dorothy E. Roberts, *Race and the New Reproduction*, 47 HASTINGS L.J. 935, 948 (1996) [hereinafter Roberts, *Race and the New Reproduction*].

⁷¹ Michelle Oberman, *The Control of Pregnancy and the Criminalization of Fetalness*, 7 BERKELEY WOMEN'S L.J. 1, 9 (1992).

⁷² *Id.*

⁷³ Note that this perception also has racial overtones. One report noted that the African-American poverty rate was 31%, despite the fact that African-Americans constituted only 12% of the United States population. Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 212 (1996).

⁷⁴ John A. Robertson, *Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction*, 59 S. CAL. L. REV. 939, 989 (1986) ("At the present time the state has no legal obligation to provide infertility services to indigents . . ."). Roberts, *Genetic Tie*, *supra* note 47, at 245 n.140 ("Indeed, a major aim of current welfare reform proposals is to discourage women on welfare from having children.").

Note a report by Svensson and Stephenson which gave an example from one state to show how some women were discouraged from using IVF. Per-Gunnar Svensson & Patricia Stephenson, *Equity and Resource Distribution in Infertility Care*, in TOUCH CHOICES: IN VITRO FERTILIZATION AND THE REPRODUCTIVE TECHNOLOGIES 161, 163 (Patricia Stephenson & Marsden G. Wagner eds., 1993). Svensson and Stephenson reported that Oregon extended its eligibility for public health insurance funds to cover all people below the federal poverty level, although limits were placed on the medical services paid with public funding. *Id.* Medical procedures were ranked by a cost-utility procedure which rated each treatment by the benefit to the patient per unit of

later, it is often the case that poor women's reproductive autonomy is instead severely limited.

B. *Women of Color*

Various studies dating from as early as the 1900s suggest that the infertility rate for African-American women is much higher than that for white women. For example, Paula Giddings reports in her book, *When and Where I Enter*, two studies which suggest the African-American infertility rate was as high as fifty percent.⁷⁵ She also reports a 1942 doctoral dissertation from Columbia University which suggested a forty-one percent childlessness rate among African-American college women.⁷⁶ In 1996, Roberts reported the infertility rate for married African-American women was one and one half times higher than married white women.⁷⁷ But despite their high infertility rate, African-American women have not participated in reproductive services at the same rate as white women.⁷⁸

Dr. Cheryl J. Sanders, in her article on African-American women and reproductive technologies, suggests one general reason for African-American women's relative absence from reproductive technologies is a less exclusive definition of family.⁷⁹ Sanders notes the idea of one mother, one father, and genetic offspring, which has led to stigmatization when that ideal cannot be met, is not necessarily an accurate family structure for African-American families. "[T]he inclusion of infertile couples and individuals as valued members of the extended family, and especially as participants in rearing children, seems to have erased or minimized whatever stigma may have been attached to infertility by society."⁸⁰

cost. Of the 714 items on the priority list, IVF was ranked 701. *Id.* A clear disincentive for women on public health insurance to use IVF.

⁷⁵ Dr. Cheryl J. Sanders, *Surrogate Motherhood and Reproductive Technologies: An African American Perspective*, 25 CREIGHTON L. REV. 1707, 1715 (1992).

⁷⁶ PAULA GIDDINGS, *WHEN AND WHERE I ENTER: THE IMPACT OF BLACK WOMEN ON RACE AND SEX IN AMERICA* 248, 379 n.30 (1984). Giddings suggests many factors were involved in this 41% rate including an unconscious revolt against being forced into the role of mothers. *Id.* at 248.

⁷⁷ Roberts, *Race and the New Reproduction*, *supra* note 70, at 939.

⁷⁸ Sanders, *supra* note 75, at 1715; see Roberts, *Genetic Tie*, *supra* note 47, at 244 ("The people in the United States most likely to be infertile are older, poorer, Black, and poorly educated. Most couples who use IVF services are white, highly educated, and affluent." (footnote omitted)).

⁷⁹ Sanders, *supra* note 75, at 1714-15; see Roberts, *Genetic Tie*, *supra* note 47, at 214 ("[B]lood ties are less significant to the definition of family in the Black community than they traditionally have been for white America.").

⁸⁰ Sanders, *supra* note 75, at 1714-15; see Roberts, *Genetic Tie*, *supra* note 47, at 231-32 (African-American culture is not dependent on the genetic ties).

Sanders suggests that more fluid definitions of family have given African-American families more alternatives in defining themselves to the extent that they are not "forced" by society to produce genetic offspring.⁸¹

While African-American women may have more choices in family structure, racial stereotypes may narrow the available opportunities of African-American women who may wish to choose IVF. As Sanders notes, the stereotypical image of the African-American woman is the "public enemy whose babies are a burden to society at large, unless, of course, she can produce sons who play football or basketball."⁸² Also, note a phone conversation Sanders reported between herself and a representative from the Surrogate Parenting Association in Louisville, Kentucky, which although specifically addressing surrogacy is applicable here: "When I asked why so few [African-Americans] participated in surrogacy arrangements, I was given several reasons: 1) [African-American] babies are easier to adopt; 2) the services are prohibitively expensive; and 3) [African-Americans] are not solely interested in biological offspring."⁸³ Sanders notes: "the experience of racism and racial discrimination breeds both skepticism and pessimism with regard to the question of whether white advances in technology and medicine are irrelevant or even inimical to the well-being of [African-Americans]."⁸⁴

C. Lesbian Women

In a 1984 report on the efficacy of single women and artificial insemination (AI), two doctors who ran an AI clinic stated they would only consider married heterosexual couples, and would not consider lesbian couples or single women for their programs.⁸⁵ Another doctor stated:

⁸¹ See generally Sanders, *supra* note 75, at 1714-15.

⁸² Sanders, *supra* note 75, at 1713.

⁸³ Sanders, *supra* note 75, at 1715.

⁸⁴ Sanders, *supra* note 75, at 1716. Roberts also reports that white women may be diagnosed with infertility, and thus pointed towards reproductive technologies, more often than African-American women.

[D]octors are more likely to diagnose white professional women with infertility problems such as endometriosis that can be treated with in vitro fertilization. In 1976, one doctor found that over 20[%] of his [African-American] patients who had been diagnosed as having pelvic inflammatory disease, often treated with sterilization, actually suffered from endometriosis.

Roberts, *Race and the New Reproduction*, *supra* note 70, at 940 (footnote omitted).

⁸⁵ Carson Strong & Jay S. Schinfeld, *The Single Woman and Artificial Insemination by Donor*, 29 J. REPROD. MED. 293, 294 (1984); see Roberts, *Genetic Tie*, *supra* note 47, at 241 n.125 (many IVF clinics accept only heterosexual married couples).

[T]he restriction of the service to 'married heterosexual unions' looks right. If, as we assume, the dominant and inescapable interest must be that of the child and his enjoying a normal upbringing—an interest, it may be added, which can be overlooked or subordinated to the couple's longing for parenthood—then deliberately to contrive its birth into a lesbian union or to a single woman would be to deny it justice.⁸⁶

One might assume lesbians also turn to IVF to meet their desire for children. Whether this is true or not, however, remains uncertain as there are no studies on the use, or attempted use, of IVF by lesbians.

"Officially" few IVF programs accept lesbians.⁸⁷ As Ann Oakley reports "[a]ccess to IVF is controlled by an outdated ideology which sees the heterosexual nuclear family as the only proper recipe for parenthood."⁸⁸ The same belief which tended to perpetuate opposition to lesbian custody⁸⁹ also pervades access by lesbians to IVF. The stereotypical beliefs maintain an exclusionary lock on access to IVF—at least officially.

V. A LARGER PATTERN OF REPRODUCTIVE CONTROL

If IVF is ever to be used for aiding women's search for reproductive autonomy, it is important to understand what drives women to turn to IVF, what expectations they have, and what are their outcomes. But one must be careful in treading this line. As Hilary Rose noted in speaking of the world's first test tube mother: "It is one thing to argue against a specific technological development which is against the interests of women . . . it is quite another to say to Lesley Brown (or any other infertile woman) that it was

⁸⁶ Strong & Schinfeld, *supra* note 85, at 294.

⁸⁷ Roberts, *Genetic Tie*, *supra* note 47, at 240-41 ("[F]ertility clinics routinely deny their services to single women, lesbians, women with genetic disorders, and women who are not considered good mothers."); see Roberts, *Race and the New Reproduction*, *supra* note 70, at 936 ("Most IVF clinics only accept heterosexual married couples as clients, and most physicians have been unwilling to assist in the insemination of single women." (citations omitted)).

⁸⁸ Oakley, *supra* note 49, at 178.

⁸⁹ Generally, homosexuality is not considered an acceptable factor in making custody decisions today. See, e.g., *S.N.E. v. R.L.B.*, 699 P.2d 875 (Alaska 1985) (it was impermissible for a court to rely on any real or imagined stigma associated with a mother being lesbian in custody decisions); *M.P. v. S.P.*, 404 A.2d 1256 (N.J. Super. Ct. App. Div. 1979) (mother's homosexuality was not a ground for change in custody); *Conkel v. Conkel*, 509 N.E.2d 983 (Ohio Ct. App. 1987) (homosexual father could not be denied overnight visitation with his children as a result of his homosexuality); *Constant A. v. Paul C.A.*, 496 A.2d 1 (Pa. Super. Ct. 1985) (mother's desire to share her lesbian relationship with her children was not a change in circumstance to warrant an alteration in custody agreement).

wrong for her to have Louise.'"⁹⁰ Ann Oakley asks, "[i]f we say that the industry of new procreative technologies should be halted, what do we say to women who want to become mothers, and who believe that investment in this industry is their only means of doing so?"⁹¹

It seems there is no way to halt reproductive technologies, nor does that seem an appropriate decision. As Oakley pointed out, it would not be equitable to protect women by punishing them. Doing so places the onus upon a woman by saying she must protect herself by refraining from using these medical advances. Instead, a better alternative would be to claim the technologies as women's own. One way of doing this is to place IVF within a larger pattern of controlling all women's reproductive autonomy. Only in this way can we really see what domination does to all women. Only in this way will medical, legal, and feminist theorists be able to realize the use of IVF to control reproductive autonomy is not an isolated issue, but rather part of a history and pattern of domination.

White women, women of color, poor women, lesbian women, all women, are being systematically denied reproductive autonomy.⁹² The forced sterilization of women, the use of Norplant to control poor women's reproduction, and the prosecution of mothers for fetal abuse, will be discussed in order to lay the groundwork for a discussion below to typify the larger pattern of controlling all women's reproductive autonomy.

A. Forced Sterilization

Believing that social problems resulted from social defects, the "socially undesirable" were sterilized as a means of race control.⁹³ The first compulsory sterilization bill to be proposed was intro-

⁹⁰ Oakley, *supra* note 49, at 180 (citation omitted).

⁹¹ Oakley, *supra* note 49, at 180 (citation omitted).

⁹² Women are being denied reproductive autonomy in many areas. See, e.g., *Lyng v. Castillo*, 477 U.S. 635 (1986) (upholding provision of Food Stamp Act which gave lesser benefits to nuclear families than to unrelated persons or extended families comprising a single household); *Harris v. McRae*, 448 U.S. 297 (1980) (denying statutory and constitutional challenge to the Hyde Amendment which prohibited the use of federal funds for certain types of abortions); *Califano v. Jobst*, 434 U.S. 47 (1977) (upholding application of the Social Security Act which provided for termination of benefits paid to a disabled dependent child of a deceased wage earner upon the child's marriage to someone not receiving benefits); *Maher v. Roe*, 432 U.S. 464 (1977) (excluding elective abortions from state Medicaid funding did not unduly burden a woman's right to an abortion).

⁹³ Steven S. Spitz, Note, *The Norplant Debate: Birth Control or Woman Control?*, 25 COLUM. HUM. RTS. L. REV. 131, 135 (1993).

duced but defeated in the Michigan legislature in 1897.⁹⁴ A second attempt, occurred in 1905 in Pennsylvania when the legislature passed "An Act for the Prevention of Idiocy."⁹⁵ The bill was vetoed by the Governor.⁹⁶ The first bill to be enacted, a 1907 Indiana bill, allowed for the sterilization of criminals, idiots, imbeciles, and rapists in state institutions upon the recommendation of a board of experts.⁹⁷

The eugenics movement in the United States quickly followed and reached its peak in the late 1920s.⁹⁸ By 1942, thirty-two states had passed compulsory sterilization bills.⁹⁹ It is estimated that over 60,000 individuals were forcibly sterilized to ostensibly eliminate social problems like "poverty, mental illness, mental retardation, disease, and criminality . . ."¹⁰⁰

In 1927, the Supreme Court addressed the issue of forced sterilization in the case *Buck v. Bell*.¹⁰¹ In this case, Carrie Buck brought a constitutional challenge to the Virginia sterilization statute.¹⁰² She was a resident of the State Colony for Epileptics and the Feeble Minded, and was chosen to be sterilized by the State Colony's superintendent because of believed "hereditary forms of insanity [or] imbecility . . ."¹⁰³ Buck was thought to be the offspring of a "feeble minded" woman and had herself recently given birth to a girl who was assumed to also be "feeble minded."¹⁰⁴ Justice Holmes, writing for the majority and affirming the decision of the lower courts, stated: "[i]t is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. . . . Three generations of imbeciles are enough."¹⁰⁵ It is interesting to note that Justice Holmes himself was an ardent eugenicist. In an article he wrote in 1915 for the *Illinois Law Review* he stated: "I believe that the wholesale social regeneration . . . cannot be affected appreciably by tinkering with the institution of property, but only by taking in hand

⁹⁴ *Id.* at 135 n.25.

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.* at 135.

⁹⁹ *Id.* at 135 n.25.

¹⁰⁰ Katz, *supra* note 19, at 742.

¹⁰¹ 274 U.S. 200 (1927).

¹⁰² *Id.* at 201.

¹⁰³ *Id.* at 205-06.

¹⁰⁴ *Id.* at 205.

¹⁰⁵ *Id.* at 207 (citation omitted).

life and trying to build a race."¹⁰⁶

It was not until fifteen years later in *Skinner v. Oklahoma*,¹⁰⁷ a case dealing with the sterilization of a male "habitual criminal,"¹⁰⁸ that the Supreme Court held the right to procreation was a "basic civil rights of man."¹⁰⁹ According to the Supreme Court, "[w]e are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race."¹¹⁰ *Skinner* clearly states the right to procreate is a fundamental right. Nonetheless, forced sterilization is still employed.

One reason for this, despite *Skinner*, is because the Supreme Court decided *Skinner* on equal protection grounds rather than directly denouncing mandatory sterilization laws and overturning the *Buck* decision.¹¹¹ As a result, sterilization laws are still on many state books and "[u]nder either its police power or *parens patriae* authority, a state retains the power to determine who should reproduce."¹¹²

The use of sterilization laws today has broadened from "incompetents" to included racial, ethnic, and class stereotypes. Dorothy Roberts argues that "abusive sterilization" is a means to control African-American women's reproductive lives.¹¹³ She believes the stereotype of African-American women as sexually promiscuous has helped devalue their roles as mothers and created a push for stricter control over African-American women's reproductive options.¹¹⁴ Further, she argues the systematic denial of African-American women's reproductive autonomy harkens back to slavery, when slave owners controlled African-American women's reproduction and used it as a means of control.¹¹⁵ As evidence of the modern day control of African-American women's reproduc-

¹⁰⁶ Spitz, *supra* note 93, at 136 n.32 (quoting Oliver Wendell Holmes, *Ideals and Doubts*, 10 ILL. L. REV. 1, 3 (1915)).

¹⁰⁷ 316 U.S. 535 (1942).

¹⁰⁸ *Id.* at 537.

¹⁰⁹ *Id.* at 541.

¹¹⁰ *Id.*

¹¹¹ Spitz, *supra* note 93, at 138-39.

¹¹² Spitz, *supra* note 93, at 139 n.46. Note, however, that despite the fact that states can still have sterilization laws, forced sterilization and consensual sterilization laws must now overcome constitutional challenges to be upheld. Julie Marcus, In re Romero: *Sterilization and Complicity*, 68 DENV. U. L. REV. 105, 107 (1991).

¹¹³ Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1427 (1991) [hereinafter Roberts, *Punishing Drug Addicts*].

¹¹⁴ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1436-39.

¹¹⁵ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1439.

tion, she points to the rates of enforced sterilization for which African-American women are inordinately represented.¹¹⁶ A 1973 study reported that 43% of women sterilized under a federally funded program were African-American, though only 33% of the patients were African-American.¹¹⁷ A 1989 study reported that 9.7% of African-American women with college educations had been sterilized, in contrast to only 5.6% of white women with college educations.¹¹⁸ Further, 31.6% of African-American women without a high school diploma were sterilized, while only 14.5% of white women had been sterilized.¹¹⁹

Roberts suggests African-American women are under a particular bind as African-American women are five times more likely to be below the poverty line, and therefore in need of government supported medical programs, than white women.¹²⁰ This unequal balance exposes African-American women to greater governmental control and thereby exposes them to greater controls over their reproductive autonomy.¹²¹ For example, one study in North Carolina reported that between 1933 and 1973 over 7500 women were sterilized; of these women, about 5000 were African-American.¹²²

African-American women, however, are not the only ones to be over represented among those sterilized. Spanish-speaking women are twice as likely to be sterilized as English-speaking women.¹²³ Of all the races in the United States, African-American women and Hispanic women are the most likely to be sterilized.¹²⁴ Davis reports that by the 1970s, 35% of all women of childbearing age in Puerto Rico had been sterilized.¹²⁵ By 1976, 24% of all Native American women of child bearing age had been sterilized.¹²⁶ Further, it is reported in 1972 alone, between 100,000 and 200,000 sterilizations were performed by government funded programs.¹²⁷

¹¹⁶ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1442-43.

¹¹⁷ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1442 n.125 (citing Dick Grossboll, Note, *Sterilization Abuse: Current State of the Law and Remedies for Abuse*, 10 GOLDEN GATE U.L. REV. 1147, 1153 n.30 (1980)).

¹¹⁸ Roberts, *Race and the New Reproduction*, *supra* note 70, at 942.

¹¹⁹ Roberts, *Race and the New Reproduction*, *supra* note 70, at 942.

¹²⁰ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1432 n.60.

¹²¹ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1432.

¹²² Ehrenreich, *supra* note 65, at 515 n.73 (citing ANGELA Y. DAVIS, *WOMEN, RACE AND CLASS* 202, 217 (1981)).

¹²³ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1442-43 n.125.

¹²⁴ Jeanne L. Vance, *Womb for Rent: Norplant and the Undoing of Poor Women*, 21 *HASTINGS CONST. L.Q.* 827, 833 (1994).

¹²⁵ Ehrenreich, *supra* note 65, at 515 n.73 (citing DAVIS, *supra* note 122, at 219).

¹²⁶ Ehrenreich, *supra* note 65, at 515 n.73 (citing DAVIS, *supra* note 122, at 218).

¹²⁷ Ehrenreich, *supra* note 65, at 515 n.73 (citing DAVIS, *supra* note 122, at 218).

Perhaps more alarming, a survey of facilities performing sterilizations in 1975 found that only 60% of the them were aware of government guidelines regulating sterilization and only 30% of facilities were trying to comply with these regulations.¹²⁸

Inconsistencies in the application of sterilization laws raise questions over the reasons for its use. In *Walker v. Pierce*,¹²⁹ a doctor required an African-American woman in labor to consent to sterilization before agreeing to assist her in delivering her fourth child.¹³⁰ Contrast this with the story told by Ruth Colker of a white law school classmate of hers who decided to be sterilized.¹³¹ The university doctor refused to allow the procedure unless the woman agreed to undergo several sessions with a psychiatrist, presumably as Colker says, to dissuade her from her decision.¹³²

Forced sterilization has been employed to selectively control women's reproductive autonomy. Specifically, forced sterilization seems to be employed most often to control the reproductive autonomy of African-American women, Latina women, and poor women. One technology pushes a subgroup of women toward fertility and another pushes a subgroup of women from fertility, though both demonstrate a loss of reproductive control. The recent trend by courts to use Norplant as a condition of parole also exemplifies this selective control.

B. Norplant as a Probation Condition

With its release to the United States market, Norplant birth control quickly became a tool for some courts to restrict women's reproductive ability. Norplant, believed to be 98.5% effective in preventing pregnancy over a five year period,¹³³ was approved by the Food and Drug Administration (FDA) on December 10, 1990 as an "acceptable means of birth control in the United States."¹³⁴

¹²⁸ Ehrenreich, *supra* note 65, at 515 n.73 (citing Davis, *supra* note 122, at 220).

¹²⁹ 560 F.2d 609 (4th Cir. 1977), *cert. denied*, 434 U.S. 1075 (1978).

¹³⁰ Vance, *supra* note 124, at 833.

¹³¹ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1443 n.130 (citing Ruth Colker, *Feminism, Theology, and Abortion: Toward Love, Compassion, and Wisdom*, 77 CAL. L. REV. 1011, 1067 n.196 (1989)).

¹³² Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1443 n.130 (citing Colker, *supra* note 131, at 1067 n.196).

¹³³ Vance, *supra* note 124, at 828 n.5 (citing American Medical Association, *Requirements or Incentives by Government for the Use of Long Acting Contraceptives*, 267 J. AM. MED. ASS'N 1818, 1818 (1992)).

¹³⁴ Spitz, *supra* note 93, at 132. Many people suggest the safety of Norplant was unknown as tests were still on-going or inconclusive. Specifically:

[a]n organization called Health Action International charges that the examiners [of tests involving Third World women as Norplant subjects]

However, like forced sterilization, Norplant has often been used disproportionately against African-American and poor women.

To use Norplant, six thin, flexible capsules containing a synthetic hormone, levonorgestrel, are inserted under the skin of the upper arm.¹³⁵ Norplant works by first suppressing ovulation with a continuous release of levonorgestrel, and second by keeping the cervical mucus thick and thereby preventing the sperm from reaching and fertilizing the egg.¹³⁶ Once inserted, Norplant can begin working within twenty-four hours if inserted within the first seven days of the woman's menstrual cycle.¹³⁷ To remove, another in-office surgical visit is required.¹³⁸ Norplant is not, however, without constraints. Norplant is not recommended for women with liver or heart disorders, blood clots, high blood pressure, breast nodules, fibrocystic disease of the breast or an abnormal breast x-ray, women with diabetes, high cholesterol or triglycerides, migraines, epilepsy, mental depression, or gallbladder or kidney diseases.¹³⁹ In women not constrained from using Norplant, side effects can include excessive or irregular vaginal bleeding, headaches, nervousness, nausea, dizziness, ovarian enlargement, dermatitis, acne, and change in appetite.¹⁴⁰

After its approval by the FDA, both state legislators and courts were quick to try to use Norplant as a means to control women's reproduction autonomy. In 1991, state legislators in Kansas attempted to pass legislation which would encourage low income women on welfare or Aid to Families with Dependent Children (AFDC)¹⁴¹ to use Norplant by offering bonuses and increases in

lost track of whole groups of women and that they gave Norplant to pregnant or lactating women. Women in Third World countries were often so frightened by the procedure for implantation that they refused to return to get the rods removed, even when they were experiencing prolonged bleeding.

Karin E. Wilinski, Note, *Involuntary Contraceptive Measures: Controlling Women at the Expense of Human Rights*, 10 B.U. INT'L L.J. 351, 357-58 (1992) (citations omitted).

¹³⁵ Spitz, *supra* note 93, at 132-33.

¹³⁶ Spitz, *supra* note 93, at 133.

¹³⁷ Spitz, *supra* note 93, at 133 n.11.

¹³⁸ Spitz, *supra* note 93, at 133.

¹³⁹ Spitz, *supra* note 93, at 134 n.17.

¹⁴⁰ Spitz, *supra* note 93, at 134 n.18.

¹⁴¹ AFDC was abolished in 1996 and replaced with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 which allowed block grants to go to states from which states can individually tailor their welfare plans. Jane C. Murphy, *Legal Images of Motherhood: Conflicting Definitions from Welfare "Reform," Family, and Criminal Law*, 83 CORNELL L. REV. 688, 734 (1998). Further, during its time AFDC itself was not without conflict. See, e.g., *Bowen v. Gilliard*, 483 U.S. 587 (1987) (AFDC requirement that a family's eligibility for benefits take into account the income of all

yearly benefits.¹⁴² A 1991 report noted that 34.6% of AFDC recipients were African-American women.¹⁴³ Compared to the fact that African-American women made up only 6.35% of the United States population, one begins to see the misuse of technology to control African-American women's reproduction. The effect of state use of Norplant, like enforced sterilization, also tended to target predominantly poor African-American women.

No Norplant bill has yet been made law; this is not, however, due to a lack of interest by state legislators. In Mississippi and Florida, state senators proposed making welfare conditional upon Norplant implantation.¹⁴⁴ In Washington and North Carolina, on the other hand, legislators proposed bills which would make Norplant implantation mandatory for mothers whose babies are born with fetal alcohol syndrome or drug addiction as determined at birth by the hospitals.¹⁴⁵ Other bills suggested increasing benefits for women who agreed to Norplant implantation. Among these states were Ohio (increased welfare benefits), Colorado (a credit to inmates for a vasectomy, tubal ligation, or Norplant implant), Connecticut (a \$700 bonus plus \$200/year thereafter for Norplant implant), and Florida (AFDC increase for Norplant or Depo Provera use).¹⁴⁶ Ex-Grand Wizard of the Klu Klux Klan and then Louisiana state representative David Duke, introduced a bill in Louisiana which in its original form offered incentives for mothers on welfare with more than one child to use Norplant.¹⁴⁷ Similarly Medicaid plans also provided funding for the insertion of Nor

family members living in the same house was reasonable); *Wyman v. James*, 400 U.S. 309 (1971) (state requirement of a home visit for recipients of AFDC served a vast purpose and did not violate recipients' privacy rights).

¹⁴² Spitz, *supra* note 93, at 141. Kansas also proposed legislation that would require a woman able to conceive and convicted of a felony possession of drugs to choose between jail or Norplant use. Wilinski, *supra* note 134, at 361-62.

¹⁴³ Spitz, *supra* note 93, at 140 n.52 (citing Stephanie Denmark, *Both Costs Life*, *ANNY*, N.Y. TIMES, Oct. 19, 1991, at A23).

¹⁴⁴ Vance, *supra* note 124, at 829.

¹⁴⁵ Vance, *supra* note 124, at 829. A problem in itself is that few rehabilitation programs will accept pregnant substance abusers. See Roberts, *Punishing Drug*, 34 *supra* note 113, at 1448; see also Wilinski, *supra* note 134, at 362 (Washington proposed a bill allowing for a petition to a court for insertion of Norplant for women who give birth to babies with fetal alcohol syndrome or drug addiction).

¹⁴⁶ Vance, *supra* note 124, at 829 n.12; see also Wilinski, *supra* note 134, at 362 (Florida's proposed bill would increase AFDC payments from \$258/month to \$400/month for Norplant use).

¹⁴⁷ Spitz, *supra* note 93, at 141, 143. Louisiana's proposed bill would pay \$100/year to poor women who choose Norplant. See Wilinski, *supra* note 134, at 362.

plant.¹⁴⁸ As of 1996, all fifty states provided funding for Norplant use through their Medicaid plans.¹⁴⁹

Critics have charged that both doctors and legislators have misused Norplant. Doctors have been criticized for enticing low-income and minority women into using Norplant without informing them of the cost of removal (\$150¹⁵⁰) or of potential side effects.¹⁵¹ Others have charged that the bills would effectively "rent a low-income women's womb for the duration of the implant" and that the bonus would act as an incentive for women to have it implanted.¹⁵² Proponents may argue that the bonuses for having Norplant implanted are too small to be a true incentive, but this may be inaccurate. Under the proposed Florida bill, for example, assistance to mothers on AFDC would increase from an average \$258/month to \$400/month upon proof the mother is using Norplant.¹⁵³ Increasing a mother's assistance by more than half is not a small incentive, but rather a bribe a low-income mother might be hard pressed to turn down in spite of any side effects from the implantation.

Courts have also attempted to use Norplant to control women's reproduction. The most notable case involved a judge conditioning parole on Norplant implantation. Darlene Johnson, a twenty-seven year old unwed mother of four, pregnant with her fifth child, had been arrested and pled guilty to violating California's penal code prohibiting corporal injury to a child.¹⁵⁴ The judge ordered her to attend counseling sessions and parenting classes, not punish her children by striking them, not smoke, and not use drugs during her pregnancy.¹⁵⁵ A month later, Johnson was sentenced to a year in jail and placed on three years probation.¹⁵⁶ In addition to the above probation conditions, Johnson was ordered to be implanted with Norplant after the delivery of her baby.¹⁵⁷ During the sentencing hearing, the judge inquired if Johnson was currently on welfare or planned to be on welfare, to

¹⁴⁸ Rachel Stephanie Arnow, *The Implantation of Rights: An Argument for Unconditionally Funded Norplant Removal*, 11 BERKELEY WOMEN'S L.J. 19, 19 (1996).

¹⁴⁹ *Id.* at 19.

¹⁵⁰ *Id.* at 21.

¹⁵¹ Vance, *supra* note 124, at 829.

¹⁵² Vance, *supra* note 124, at 830.

¹⁵³ Vance, *supra* note 124, at 831.

¹⁵⁴ Spitz, *supra* note 93, at 143, n.72 (citing Mark A. Stein, *Judge to Let Birth Control Order Stand*, L.A. TIMES, Jan. 11, 1991, at A3).

¹⁵⁵ Spitz, *supra* note 93, at 144.

¹⁵⁶ Spitz, *supra* note 93, at 144.

¹⁵⁷ Spitz, *supra* note 93, at 144.

which she answered yes.¹⁵⁸ Then, stating a concern for her children and her parenting ability, the judge asked if she would be willing to be implanted with a new birth control, similar to the pill, which lasted five years and had recently been approved by the FDA.¹⁵⁹ Johnson agreed without having been informed of the side effects for her particular conditions—high blood pressure, diabetes, and a heart murmur—which excluded her from its use.¹⁶⁰

Within the week, her attorney, who had not been at the probation hearing, asked the court to set aside the terms of the probation in view of Johnson's medical unsuitability for Norplant treatment, her constitutional right to privacy, and the statutory argument that Norplant was unrelated to her rehabilitation.¹⁶¹ The judge refused, stating that "[i]t is in the defendant's best interest and certainly in any unconceived child's interest that she not have any more children until she is mentally and emotionally prepared to do so."¹⁶²

The case was appealed but became a moot issue when Johnson violated the terms of her parole to not use drugs, and was sentenced to a prison term.¹⁶³ The appeals court subsequently refused to address the constitutionality of using Norplant as a condition of parole.¹⁶⁴

Johnson is not, however, the only woman for whom Norplant has been used as a condition of parole. In Nebraska, twenty-one year old Michelle Carlton agreed to use Norplant as part of her plea agreement.¹⁶⁵ In Texas, nineteen year old Ida Jean Tovar, an unmarried mother of three, agreed to the use of Norplant in her plea agreement.¹⁶⁶ Again in Texas, Cathy Lanel Knighten, a twenty-three year old poor woman charged with smothering her infant, agreed to a Norplant implantation as part of a plea agreement.¹⁶⁷

Like the forced sterilization of women, which has tended to result in the misuse and abuse of African-American, Latina, and

¹⁵⁸ Stein, *supra* note 154, at A3.

¹⁵⁹ Michael Lev, *Judge is Firm on Forced Contraception, but Welcomes an Appeal*, N.Y. TIMES, Jan. 11, 1991, at A17; Stein, *supra* note 154, at A3.

¹⁶⁰ Lev, *supra* note 159, at A17.

¹⁶¹ Spitz, *supra* note 93, at 146; Stein, *supra* note 154, at A3.

¹⁶² Lev, *supra* note 159, at A17; Spitz, *supra* note 93, at 146.

¹⁶³ Spitz, *supra* note 93, at 147 n.91.

¹⁶⁴ Spitz, *supra* note 93, at 147 n.91; *People v. Johnson*, No. F015316, 1992 WL 685375, at *1 (Cal. Ct. App. Apr. 13, 1992).

¹⁶⁵ Spitz, *supra* note 93, at 144 n.78.

¹⁶⁶ Spitz, *supra* note 93, at 144 n.78.

¹⁶⁷ Spitz, *supra* note 93, at 145 n.78.

poor women's reproductive autonomy, the use of Norplant has also been used to control the reproductive autonomy of women. Note Jeanne Vance's assessment of this situation:

[T]he public perception is that welfare mothers are unmarried and non-white. Therefore, the Norplant bills may draw support from prejudice and racial stereotyping. Certainly racism provides a partial motivation, even if only on a subconscious level, for some politicians and medical professionals who seek to prevent women of color from reproducing.¹⁶⁸

C. Fetal Abuse Laws

As of 1996, "two hundred women in thirty-five states had been charged with abusing an unborn child."¹⁶⁹ Fetal abuse laws have also been employed to selectively control women's reproductive autonomy. The use of fetal abuse laws—in addition to the fact that they place the interests of the embryo higher than that of the mother—has been shown to place a higher burden on African-American and poor women than on white or middle-class women.¹⁷⁰ One study noted that although there were equal rates of drug use among African-American and white women at one clinic, African-American women were nearly ten times more likely than white women to be reported to state agencies for drug abuse.¹⁷¹ This same study also noted that poor women were more likely than middle class women to be reported to the authorities.¹⁷² In Pinellas County, Florida, a study comparing the tests of pregnant women receiving care from either public or private clinics found that 60% of the 133 women reported to health authorities had incomes less than \$12,000, while only 8% of those reported had incomes of \$25,000 or more a year.¹⁷³ It has been suggested that one reason for this disparity is that doctors, in this case white and middle-/upper-class, identified more readily with someone from their own

¹⁶⁸ Vance, *supra* note 124, at 832-33 (citation omitted).

¹⁶⁹ Murphy, *supra* note 141, at 713. Prosecution for fetal abuse has usually taken two forms: prosecution under drug trafficking laws, or prosecution under criminal child abuse and neglect statutes. The successful prosecution under drug trafficking laws has been overturned on the grounds that these statutes prohibit trafficking to "born persons." Prosecution under criminal child abuse and neglect statutes has created litigation over whether a fetus is to be considered a child for the purposes of the statute. Murphy, *supra* note 141, at 713-14.

¹⁷⁰ Oberman, *supra* note 71, at 9 n.36.

¹⁷¹ Oberman, *supra* note 71, at 9 n.36 (citing Ira J. Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202, 1204 (1990)).

¹⁷² Oberman, *supra* note 71, at 9 n.36 (citing Chasnoff, *supra* note 171, at 1205).

¹⁷³ Oberman, *supra* note 71, at 9 n.36 (citing Chasnoff, *supra* note 171, at 1205).

socio-economic background, and were thus less likely to report suspected abuse by white or middle-class women to authorities than for African-American or poor women.

Note the experience of twenty-three year old Jennifer Clarise Johnson, the first woman convicted of exposing her baby to drugs while pregnant,¹⁷⁴ as an example of this phenomenon. Johnson was prosecuted with two counts of delivering a controlled substance to a minor. The delivery supposedly occurred in the sixty seconds after birth and before the umbilical cord was cut.¹⁷⁵ The conviction was upheld by the appeals court, marking the first time a law prohibiting distribution of drugs to children under eighteen was successfully used as a fetal protection law and upheld by a state appeals court.¹⁷⁶

The Johnson case, however, is not an isolated incident. Hoffman reports that between 1987 and 1991 at least fifty "fetal abuse" cases were brought in nineteen states and the District of Columbia.¹⁷⁷ But as one study reported, of fifty-two defendants in fetal abuse law cases, thirty-five were African-American, two were Latina, and one was Native American. Only fourteen of the women were white.¹⁷⁸ Also note a 1990 *The New York Times* report stating that of sixty women charged with fetal abuse, 80% were minorities.¹⁷⁹ In Florida, as of 1991, ten of the eleven criminal cases for fetal abuse were brought against African-American women. Further, in South Carolina from 1989 to 1991, seventeen of the eighteen women charged with criminal neglect or distributing drugs to a minor were African-American.¹⁸⁰ These statistics suggest that fetal abuse laws are also being used to negatively control minority and poor women's reproductive autonomy.

¹⁷⁴ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1420.

¹⁷⁵ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1420. There are many examples of prosecution under fetal abuse laws. See generally Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1420 n.2.

¹⁷⁶ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1420 n.2 (citing Tamar Lewin, *Court in Florida Upholds Conviction for Drug Delivery by Umbilical Cord*, N.Y. TIMES, Apr. 20, 1991, at 6).

¹⁷⁷ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1421 n.5 (citing Jan Hoffman, *Pregnant Addicted—and Guilty?*, N.Y. TIMES MAGAZINE, Aug. 19, 1990, at 32, 35).

¹⁷⁸ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1421 n.6 (referring to a memorandum of the ACLU Reproductive Freedom Project).

¹⁷⁹ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1421 n.6 (citing Gina Kolata, *Bias Seen Against Pregnant Addicts*, N.Y. TIMES, July 20, 1990, at A13).

¹⁸⁰ Roberts, *Punishing Drug Addicts*, *supra* note 113, at 1421 n.6.

VI. FINDING REPRODUCTIVE AUTONOMY

There are many layers from which to analyze gender inequality within reproductive technologies. One is by viewing the bias within the technology itself. With IVF the inequality results from women being placed in competition with the technology, doctors, and views of informed consent. Inequality can also become apparent from viewing those who do not use IVF and how those women have their reproductive autonomy controlled outside IVF use. All women experience domination through the loss of their reproductive autonomy. From this common domination, it is possible to move the discussion to fighting and ending the domination rather than simply focusing on the differences within the experience of domination.

This Note has attempted to demonstrate that IVF has the potential to be used to control women's reproductive autonomy both as an individual technology and as part of a larger pattern of control. When one views IVF as part of a system of gender control, it becomes easy to see the systematic domination of women through restrictions on all women's reproductive autonomy whether it is in preventing or promoting their fertility.

Only by recognizing the limits that reproductive technologies place on women can women gain control over the technology and begin the quest to define their own reproductive autonomy.