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Woman Scorned?: Resurrecting Infertile Women's Decision-Making Autonomy

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WOMAN SCORNED?:
RESURRECTING INFERTILE WOMEN’S DECISION-MAKING AUTONOMY

Jody Lyneé Madeira†

ABSTRACT
Legal scholarship portrays women as reproductive decision-makers in odd and conflicting ways. The disparity between depictions of infertile women and women considering abortion is particularly striking. A woman seeking infertility treatment, even one who faces no legal obstacles, is often portrayed as so emotionally distraught and desperate that her ability to give informed consent is potentially compromised. Yet, the legal academy has roundly rejected similar characterizations of pregnant women considering abortion, depicting them as confident and competent decision-makers. This Article argues that, compared to portrayals of women seeking abortions, legal scholars’ characterizations of infertile women inexplicably deny women’s ability to critically assess the health risks and life benefits of fertility treatments. These constructions perpetuate emotional paternalism; undermine the dignity, autonomy, and capacity of infertile women; and justify restrictions on decision-making in the Assisted Reproductive Technology (ART) context. Infertility may well produce emotional distress; however, the construction of infertile women as governed by desperation unnecessarily impugns their capacity for autonomous decision-making. Overemphasizing infertile women’s desperation to conceive diminishes the scholarly inquiry into the in vitro fertilization (IVF) experience, denying such women their reproductive autonomy. Such inaccurate and demeaning constructions of infertile women ignore available clinical research and have serious ideological and practical consequences. It is therefore crucial to unmask and reframe such undignified and inaccurate stereotypes to prevent them from being incorporated into jurisprudence or legislation.

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INTRODUCTION

The lynchpin of medical decision-making has long been informed consent; patients are treated as rational, autonomous beings capable of reaching appropriate decisions about their own medical treatment.¹ But both this informed consent ideal and its cognitive emphasis are now under assault.² These efforts have resulted in a growing awareness of emotion’s effects upon decision-making, and rumblings of discontent with cognitive theories of competence. To these ends, some scholars challenge the very notions of autonomy and rationality.³ A few suggest that many patients genuinely prefer to have doctors or family members make decisions for them.⁴ Still others question whether even rational individuals can reach reasoned decisions in the face of emotionally trying circumstances, and would support intrusions on patient autonomy to override what they see as ill-considered choices.⁵

Women are disproportionately likely to be placed in this latter group. Historically, much of Western society and science has viewed women as excessively emotional beings with questionable decision-making ability.⁶ While wholesale assaults on women’s rationality have ebbed, these doubts regularly reemerge when reproduction is at issue, justifying the imposition of tight social controls upon their reproductive capacities and decision-making opportunities. Challenges to women’s autonomy and capacity for

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³ See, e.g., SCHNEIDER supra note 2, at 47-108, 102 (1998) (problematizing autonomy and stating that no truly rational decision is possible).

⁴ Id. at 35-46, 85-87 (discussing quantitative and qualitative research suggesting that not all patients want to make their own decisions and their reasons for doing so).

⁵ Id. at 63 (stating that decisions may be “warped” by various emotions); id. at 89-90 (stating that sometimes patients have been thankful when physicians persisted in treatment that went against their wishes). See also EZEKIEL J. EMANUEL & LINDA L. EMANUEL, FOUR MODELS OF THE PHYSICIAN-PATIENT RELATIONSHIP, 267 JAMA 2221 (1992) (discussing various models of physician-patient relationships, including a paternalistic model of the physician-patient relationship where the physician decides which is best).

⁶ See infra notes 141 to 155.
self-governance, however, are often misguided, misogynistic, and altogether erroneous. Moreover, these claims inspire ill-considered legislation, as demonstrated by the legislative responses following the birth of Nadya Suleman’s (“Octomom’s”) octuplets.

On January 26, 2009, Suleman, an unemployed single mother of six who was receiving public assistance, gave birth to octuplets conceived through in vitro fertilization (IVF) using an ex-boyfriend’s sperm. Suleman’s story engendered profound controversy, with her decision to transfer six embryos inspiring sharp criticism. Fertility clinics across the United States were intensely scrutinized, spurring legislative attempts to preempt women and their doctors from making similar decisions in the future. In Georgia, the proposed “Ethical Treatment of Human Embryos Act” proposed that a living embryo was a “biological human being” that could not be destroyed and restricted the number of embryos that could be created and transferred in an IVF cycle. The Georgia Senate eventually passed an amended form of the bill stating that IVF embryos can only be created to initiate pregnancy. Missouri legislators considered a similar measure providing that physicians could transfer only as many embryos as recommended by the American Society for Reproductive Medicine.

Though these proposed acts were explicitly concerned with the ethics of assisted reproductive technologies, implicit in each is the argument that women and their physicians cannot be trusted to make ethically correct decisions regarding when to undergo IVF and how many embryos to transfer. Such legislation is also problematic because it undermines doctors’ treatment discretion and thwarts customization of IVF protocols, which could have dire consequences for women for whom it is medically necessary to transfer more than two or three embryos.

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7 See, e.g., Randal C. Archibold, Octuplets, 6 Siblings, and Many Questions, N.Y. TIMES, Feb. 4, 2009, at A14. In IVF, a certain number of fertilized embryos (ranging from 1 to 3) are transferred back into the intended mother’s uterus. Much of the controversy stemmed from rumors that Nadya elected to transfer six embryos (two of which split into identical twins). Octuplets’ mom says she had 6 embryos implanted, ASSOCIATED PRESS, February 6, 2009.


9 S.B. 169, http://www1.legis.ga.gov/legis/2009_10/versions/sb169_As_introduced_LC_37_0857_2.htm. The act stated that “in the interest of reducing the risk of complications for both the mother and the transferred in vitro embryos, including preterm birth associated with higher-order multiple gestations,” doctors could only create the number of in vitro embryos in a single cycle as were permitted to be transferred in that cycle; women under 40 using their own eggs could have a maximum of two embryos transferred per cycle, those over 40 using their own eggs could transfer three, and women using donor eggs or adopted embryos could transfer two regardless of age. The act stated that “in the interest of reducing the risk of complications for both the mother and the transferred in vitro embryos, including preterm birth associated with higher-order multiple gestations,” doctors could only create the number of in vitro embryos in a single cycle as were permitted to be transferred in that cycle; women under 40 using their own eggs could have a maximum of two embryos transferred per cycle, those over 40 using their own eggs could transfer three, and women using donor eggs or adopted embryos could transfer two regardless of age. Id.


The controversy surrounding how and why Suleman conceived her octuplets and the legislation that this strange incident inspired illustrates how women’s reproductive potential induces trepidation and disquiet in contemporary society. In fact, the “Octomom” controversy underscores the decoupling of women’s sexuality from reproduction, intensifying questions of ethics and morality. But infertile women are not the only population that is seen as “reproductively troubled” and that faces particularly complex ethical and moral questions and potential social stigma; women carrying unwanted pregnancies have also long been in the spotlight of controversy. At first glance, an infertile woman attempting to conceive through assisted reproductive technologies (ART) and a fertile woman considering abortion appear to be diametric opposites, individuals with clearly contradictory needs and priorities. One wants a child; the other does not. One cannot conceive a child; the other can. Abortion in the United States inspires regulatory schemes; IVF, until recently, has not.

Closer examination, however, reveals many important similarities between women in these two situations. Both may be perceived as emotional or desperate. Both acquire the liminal role of medical patient, a status that is simultaneously empowering and subordinating; one may seek or refuse medical treatment, but at the same time is grouped with the “unwell” and vulnerable. Most significantly, however, both seek to alter the “natural” course of fertility and attempt to use reproductive technologies to make significant reproductive choices about how to deal with crises—achieving, or avoiding, motherhood. Both infertile women and pregnant women considering abortion have been portrayed by legal scholars as weak, irrational, or outright incompetent.

But while there has been robust, passionate defense of pregnant women’s ability to choose abortion, there have been only isolated attempts to defend infertile women’s decision-making capacity. This disparity is profoundly evident in legal scholarship, which resounds with sharp criticism of the “woman-protective” discourse on abortion that claims that women are predisposed toward motherhood, cannot rationally elect to terminate fetal life, and must be subject to informational disclosures and reflective periods before giving “informed consent” to abortion. By contrast, some legal scholars’ depictions of infertile women espouse protectionism, asserting that infertile women’s desperation jeopardizes their ability to consent to fertility treatments. These scholars claim that, for infertile women “desperate” to conceive, “the power of wishful thinking obscures rational

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13 For instance, at legal conferences academics have begun to refer to Nadya Suleiman by her legal name instead of the more derogatory “Octomom” as a sign of respect.

14 See infra notes 93-96.

deliberation," rendering them incapable of weighing the risks and benefits of treatment. Yet, clinical research belies any claim that distress leads to incapacity and finds that severe emotional distress is most likely not at the informed consent stage but after multiple unsuccessful treatment cycles, if at all.  

It is understandable that, to date, scholars have focused their energies and resources on combating more imminent and dangerous threats of regulatory and judicial constraints on abortion decision-making. What feminist scholars have accomplished in the abortion context—a thorough repudiation of images of women as unfit decision-makers—must now be accomplished in the infertility context. Given recent legislative action, this issue has become urgent. We must take a hard look at the types of legislation that have been and will likely be introduced, scrutinizing the limits they would place on women’s decision-making as well as the understandings of women as decision-makers that underlie them.

Part I of this Article explicates how and why contemporary characterizations of infertile women conflict so profoundly with legal constructions of women with unwanted pregnancies. It first describes legal scholars’ protectionist constructions of infertile women. Thereafter, it contrasts these paternalistic characterizations with feminist legal scholars’ empowering depictions of pregnant women considering abortion that have evolved in reaction to legislative and judicial constraints on the abortion decision. Finally, this Article explores possible reasons for the strong tensions between these two constructions of women as reproductive decision-makers.

In Part II, this Article argues that these constructions of infertile women are scientifically and pragmatically inaccurate. These depictions are contradicted by clinical psychological and psychiatric research that acknowledges a link between infertility and emotional distress, but does not correlate distress with incompetence. In addition, these constructions are disrespectful of women’s reproductive autonomy; like fertile women, infertile women can freely choose to attempt to conceive a child. Finally, such portrayals misconstrue the productive role that emotion can play in reproductive and medical decision-making for all women making reproductive decisions.

In Part III, this Article discusses the grave consequences of allowing current constructions of infertile women in legal scholarship to stand unchallenged. Drawing upon sociological theory, it documents how failing to combat protectionist portrayals of infertile women inevitably reinforces paternalistic attitudes towards women and reproductive decision-making as such constructions diffuse into mainstream society.


17 See infra note 176.
I. WOMAN INEPT, WOMAN ADEPT: CONFICTING LEGAL IMAGES OF WOMEN’S DECISION-MAKING AUTONOMY

A. Infertile Women in Legal Scholarship

Constructions of pregnant women considering abortion as inferior decision-makers have originated primarily in state and federal legislation and judicial decisions.\(^\text{18}\) Constructions of infertile women as poor decision-makers, however, have originated primarily in legal scholarship. This literature questions infertility patients’ decision-making in a handful of contexts, including whether strong emotions warp decisions to undergo fertility treatment, whether patients can adequately comprehend treatment risks and benefits, and whether patients can cogently decide matters such as embryo disposition in the event of death or divorce prior to an IVF cycle. Common law courts—the usual arbiters of legal competency—have been largely silent as to the legal implications of infertile individuals’ emotional condition; no published case has invalidated IVF informed consent or embryo disposition forms on the grounds of parties’ emotional distress, desperation, or other strong emotion.\(^\text{19}\)

Legal scholars who describe the emotional effects of infertility at best recognize the affective dimensions of fertility treatment and at worst depict these factors as overwhelming reason, free will, and perhaps even the capacity for informed consent. Such scholars usually acknowledge infertility’s considerable emotional consequences, particularly depression.\(^\text{20}\) They recognize that IVF patients experience “extreme emotional

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\(^\text{18}\) In contrast, it is only recently that legislation has been proposed that would constrain infertile women’s decision-making (primarily by limiting how many embryos can be transferred in a cycle). Other forms of state legislation affirmatively encourage citizens to access fertility treatment, such as provisions that mandate that health insurance provide coverage for treatment procedures and medications, often including multiple cycles of intra-uterine insemination (IUI) and IVF. See, e.g., ARK. CODE ANN. § 23-85-137 and § 23-86-118 (Mitchie 1987); CAL. HEALTH & SAFETY CODE § 1374.55; CAL. INSURANCE CODE § 10119.6 (West 1989); CONN. GEN. STAT. § 38a-536 and § 38a-509 (1989, 2005); HAWAII REV. STAT. § 431:10A-116.5 and § 432.1-604 (1989, 2003); ILL. COMP. STAT. ch. 215, § 5/356m (1991, 1996); MD. CODE ANN., INS. § 15-810 (2000); MASS. GEN. LAWS ANN. ch. 175, § 47H, ch. 176A, § 8K, ch. 176B, § 4J, ch. 176G, § 4 and 211 MASS REGS CODE tit. 37.00 (1987, 2010); MONT. CODE ANN. § 33-31-102(2)(v), et seq. (1987); N.J. STAT. ANN. § 17:48-6x, § 17:48A-7w, § 17:48E-35.22 and § 17B:27-46.1x (2001); N.Y. INS. LAW § 3216 (13), § 3221 (6) and § 4303 (1990, 2002); N.Y. PUB. HEALTH LAW § 2807-v (2002); OHIO REV. CODE ANN. § 1751.01 (A) (7) (1991); R.I. GEN. LAWS § 27-18-30, § 27-19-23, § 27-20-20 and § 27-41-33 (1989, 2007); TEX. INS. CODE ANN. § 1366.001 et seq. (1987, 2003); W. VA. CODE § 33-25A-2 (1995).

\(^\text{19}\) Only one case addresses infertile individuals’ vulnerability, and does so in dicta; in U.S. v. Stover, a criminal appeal involving adoption fraud, the government argued that “many of defendants’ victims had problems with infertility and suffered the attendant emotional effects of that condition,” that the defendants “targeted those clients' emotional vulnerability by promising a ‘quick fix,” and asked the court to uphold a vulnerable victims sentencing enhancement even though the district court “fail[ed] to cite the infertility of some of the victims as a ground for finding unusual vulnerability.” 93 F.3d 1379, 1383-84 (8th Cir. 1996). Finding that infertile parents looking to adopt were not vulnerable victims as a class, the Eighth Circuit left the door open a crack for future cases: “given the proper set of facts, a person’s infertility, if known to the defendant, might support a finding of particular susceptibility to adoption-related fraud.” Id. at 1388.

\(^\text{20}\) Judith F. Daar, Regulating Reproductive Technologies: Panacea or Paper Tiger?, 34 HOU. L. REV. 609, 629 (1997) (“In numerous psychological studies, researchers have found that infertile women frequently suffer from severe depression.”).
distress” before and during infertility diagnoses, and state that undergoing long-term infertility treatments can exhaust emotional, physical, and financial resources. They note that infertile couples experience loss of control, stress, anger, stigma isolation, self-doubt, guilt, lowered self-esteem, and impaired health, relationships and ambitions, all symptoms contributing to depression. They portray the struggle to overcome infertility as an all-consuming quest: “It is almost as if the infertile couple is emotionally trapped until a healthy child is born.” But they also make three problematic claims: that infertile women are desperate and obsessed, that these overpowering emotions jeopardize their decision-making capacity, and that undergoing fertility treatment is most often an irrational decision.

Desperation and obsession become key focal points in such discussions, obscuring the distinctions between these emotions and clinical emotional distress. IVF patients are deemed “emotionally weakened” by their failure to conceive a child. Gooden remarks that “an infertile couple is often willing to go to any extent to have a child, including signing an informed consent agreement.” Similarly, Strong states that “desperate” infertile couples “experiencing a great deal of emotional turmoil because of their infertility. . . . often are willing to do almost anything to have a baby.” Kraweic asserts that, “for some prospective parents, the desire for a family is so strong that they will stop at virtually nothing to procure a child. . . . attempts to acquire a child often stop only when success is attained or access to funds runs out.” The consensus is that these myriad vulnerabilities


22 Keith Alan Byers, Infertility and In Vitro Fertilization: A Growing Need for Consumer-Oriented Regulation of the In Vitro Fertilization Industry, 18 J. LEGAL MED. 265, 270 (1997) (noting that “[d]ifficulty in conceiving a child is a deeply emotional experience”); Pratt, supra note 21, at 1128 (“Long-term treatment of infertility exacts a heavy toll, both emotionally and financially. Infertility often has a devastating emotional effect, especially on women”). See also Daar, supra note 116, at 629; Vincent F. Stempel, Procreative Rights in Assisted Reproductive Technology: Why the Angst?, 62 ALB. L. REV. 1187, 1197 (1999) (“As well as being physically and emotionally draining to a woman, the IVF process is often painful and intrusive.”).

23 Waldman, supra note 16, at 923.


25 Negar Nicole Jacobs & William T. O’Donohue, Coping With Infertility: Clinically Proven Ways of Managing the Emotional Roller Coaster 70-72 (2007) (defining depression as including sadness, inactivity, feelings of worthlessness, feelings of guilt, difficulties in relationships, physical symptoms (difficulty sleeping, weight loss/gain, difficulty in thinking/concentrating/decision-making, sexual dysfunction), and thoughts of death).

26 Id. at 271.


29 Strong, supra note 15, at 275.

could potentially leave infertility patients open to emotional manipulation and exploitation.\textsuperscript{31}

More problematic, however, are assertions that patients’ emotions and the technological complexities of infertility treatments undermine women’s capacity to make informed choices between undergoing infertility treatments or accepting involuntary childlessness. Many articles describe infertile women not as emotionally vulnerable but as emotionally unstable. Desperation cannot co-exist with temperance or rationality. It is often unclear whether scholars see infertility patients who persist with treatment as merely tenacious or as naïve and gullible. The Model Assisted Reproductive Technology Act recommends psychological counseling for infertility patients because “the goal of promoting informed decision-making can be seriously hindered by emotional factors.”\textsuperscript{32} Shapo comments on infertility’s “fundamental emotional nature,” opining that “the usual premises of bargaining, efficiency, and rationality generally do not hold for people embarking on a program of IVF.”\textsuperscript{33} Goodwin asserts that motherhood through ART is an “illusory choice,” arguing that “ART as a technology that affords “choice” can blind couples to the less desirable outcomes and unanticipated economic and emotional strains associated with this technology.”\textsuperscript{34} While infertile women look upon ART as “more than a rational choice . . . a blessing,” others—such as some legal scholars—are quick to assert that ART is a “collective gamble” that “if taken without caution may result in tremendous emotional and physical pain as well as financial loss and the health impairment of children.”\textsuperscript{35} Thus, persistence in treatment is primarily framed as a somewhat irrational choice made by persons desperate to have a biological child.\textsuperscript{36}

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\textsuperscript{31} Byers, supra note 22, at 272 (“Considering the societal pressure placed on infertile couples, the intense emotions frequently associated with infertility, and the internal desire of those affected by infertility to have their own biological children, there is little doubt that many infertile couples could be vulnerable and subject to exploitation by third parties offering to assist them in their quest for a child.”).

\textsuperscript{32} Sara Cotton et al., Model Assisted Reproductive Technology Act, 9 J. GENDER RACE & JUST. 55, 66 (2005).

\textsuperscript{33} Helene S. Shapo, Frozen Pre-Embryos and the Right to Change One’s Mind, 12 DUKE J. COMP. & INT’L LAW 75, 103 (2002).

\textsuperscript{34} Michele Goodwin, Assisted Reproductive Technology and the Double Bind: The Illusory Choice of Motherhood, 9 J. GENDER RACE & JUST. 1, 4 (2005).

\textsuperscript{35} Id. at 19.

\textsuperscript{36} A Note in the Harvard Law Review asserts that “consumers in the market for infertility treatment may be especially vulnerable to emotional manipulation or misinformation for a variety of reasons,” and that “the highly technical nature” of treatments offers “a bewildering array of information that makes it difficult for consumers to make an informed choice.” In addition, the Note continues, because infertility is “usually an emotionally charged subject,” an infertility patient “may . . . continue treatment even when it is very unlikely to produce positive results.” Note, In Vitro
Some scholars focus more intently on the legal implications of these “irrational” choices, especially on infertility patients’ diminished capacity to give informed consent because emotions obscure or defeat rational deliberation. This not only conflates desperation with pathological distress, but it contradicts clinical research findings in at least two respects: it fails to distinguish distress caused by the treatment itself from distress existing at the time of consent, and it conflates predictable emotions, such as the desire to have a child, from pathological ones that interfere with appropriate decision-making.

Waldman describes infertility patients as the victims of “selective perception,” who “selectively construct evidence that confirms their existing beliefs and desires.”37 Hopeful and anxious, infertility patients “have difficulty absorbing medical information and rationally evaluating the risks and benefits of various treatment options.”38 Thus, Waldman claims, informed consent is “seriously hindered by the emotional vortex in which reproductive medicine occurs” because “[p]atients often resist thoughtfully considering these possibilities and must be pressed to seriously evaluate the medical risks” of ART.”39 Warnings are drowned out by emotion, leaving infertile women potentially adrift in the wild depths of the in vitro sea:

Possession of a high level of technical information, however, does not necessarily yield an appreciation of the low likelihood of success promised by these innovations. The power of wishful thinking obscures rational deliberation. Infertile women will often opt for any treatment option presented, regardless of the physical, psychological, or financial price. This is true even where the chances for success are distinctly remote.40

This alleged incapacity for informed consent also renders problematic the embryo disposition form that patients must complete instructing the fertility clinic how to dispose of embryos after divorce, the death of one or both partners, or other situations. Some voice concern that patients make advance determinations assuming they will have biological children before dispositions take effect,41 with inability to predict future events undermining contractual capacity. Emotions supposedly interfere; one must consider the “fragile emotional and physical state of the patient at the time the agreement is entered into,” and “parties rarely can fully appreciate the impact of their decisions when the agreements are signed, given the highly emotional circumstances of the agreement.”42

In this vein, Waldman asserts that “couples, on what they fervently hope will be the cusp of parenthood, would be disinclined to contemplate seriously what should be done

37 Waldman, supra note 16, at 922.
38 Id. at 922-23.
39 Id. at 924.
40 Id. at 923-24.
41 Coleman, supra note 21, at 109.
42 Boatman, supra note 24, at 305, 304.
in the event they lose personal capacity or divorce before having a child.” Such problems are compounded, she cautions, by combining the embryo disposition form with other documents, which “will likely lead to psychological overload, and glossing over the import of the information being conveyed.” Similar concerns motivate Gooden to impose a framework that excludes emotions altogether, such as conceptualizing embryo disposition as property distribution.

The specter of desperation haunts constructions of infertile women so pervasively that they are unlikely to be seen as assertive and educated medical consumers electing ART after a calculated assessment of risks and benefits. Nonetheless, some scholars assert that “the people who purchase fertility services don’t see themselves as participating in a commercial relationship.” Here as elsewhere, infertile individuals’ desperation is seen to dictate choices. As Kraweic notes, “Prospective parents . . . frequently do not engage in extensive price comparison or bargaining over fees; change providers only reluctantly, even when faced with a lack of success through a given provider; and behave like desperate parents, rather than rational consumers, when weighing their purchasing options.”

In the infertility context, courts that face real-world decisions have largely supported women’s capacity to make reproductive decisions. In contrast, legal scholars have focused on the potential for exploitation of infertile women in a field with relatively little oversight. This exploitation comes from multiple sources: societal pressures to reproduce, the financial incentives for fertility clinics to encourage women to continue with low probability or even dangerous treatments, and the commodification of women’s reproduction in the context of a market that imposes price limits on suppliers but not clinics or patients. But in developing these critiques (some of which have substantial merit), scholars construct images of infertile women that may carry implications outside of the immediate context. The common denominator in these depictions is emotional excess, incapacity, irrationality. The critiques focus too much on infertile women’s intrinsic limitations and less on the source of oppression (or alleged oppression) that created the writers’ concerns. Doctors, husbands, and social pressures to reproduce should occupy center stage in these narratives, but rarely do. Instead, women’s emotions and frailties take on disproportionate emphasis. This logic is more woman-destructive than woman-protective, undermining decision-making autonomy and perpetuating invidious stereotypes.

Legal scholars’ constructions of infertile women are strikingly similar to those of early radical feminists. Although legal scholars locate infertile women’s incapacity in

43 Waldman, supra note 16, at 924, 925.
44 Id.
45 See Gooden, supra note 28, at 93 (stating that “courts should recognize a valid property interest in embryos” and that under the property perspective “the procreational rights of the parties will not control the decision, thereby making the disposition less emotional.”).
47 Kraweic, supra note 30, at 7-8.
48 See, e.g., Davis v. Davis 842 S.W.2d 588, 597 (Tenn. 1992) (stating that informed consent and disposition agreements should be biding even though “we recognize that life is not static, and that human emotions run particularly high when a married couple is attempting to overcome infertility problems.”).
49 See infra notes 20-36.
50 It is admittedly an oversimplification to divide feminism into “radical” and “liberal” camps. However, an elaborate discussion of the various feminist perspectives—a complex topic—is beyond
emotion and radical feminists in patriarchy, both have the same policy implication: that infertile women should be prevented from making treatment choices that they are ill-equipped to make in their vulnerable state.

As early as the 1960s, feminists greeted advancements in reproductive technologies enthusiastically, as ways for women to avoid unwanted pregnancies, so that they were no longer defined in terms of motherhood. This began to change, however, when reproductive technologies also made motherhood more widely attainable. As ART grew more commonplace, its potential consequences alarmed radical feminists. ART placed feminists in a quandary, offering expanded choices while “threatening women’s reproductive freedom.” Widespread radical feminist opposition to ART dates from the 1970s; international mobilization against ART was accomplished by 1985 through the Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRAGE), an influential group advocating for a ban on “dehumanizing” ART methods that are “part of women’s oppression and . . . violence against women . . .”

Radical feminist writers expressed concern for infertile women’s social position and the risks of ART, positing that infertility was not a medical condition or physiological defect but a symptom of patriarchal conditioning. They asserted that infertile women sough to conceive to satisfy problematic psychological or psychiatric needs. This

the purposes of this article. Radical feminism explicates how patriarchal relationships and institutions oppress women and calls for profound social change. “Radical” denotes “of or pertaining to the root,” which radical feminists “locate in patriarchal gender relations, as opposed to legal systems (liberal feminism) or class conflict (socialist feminism or Marxist feminism).” http://en.wikipedia.org/wiki/Radical_feminism.

52 In 1989, Christine St. Peter observed that “Western feminists have only just learned to acknowledge (again) that fertility, pregnancy, birth, and child-rearing are cultural achievements, now, from another source, comes a troubling new challenge to human procreation: the high-tech management of every aspect of female reproduction.” Christine St. Peter, Feminist Discourse, Infertility, and Reproductive Technologies, 1 NWSA JOURNAL 353, 355 (1989).
55 St. Peter, supra note 52, at 355 (rejecting the need to “buy the definition of infertility as disease, then buy the need for medically intrusive, expensive, and even dangerous “cures””).
56 In her influential book The Mother Machine, Gena Corea painted a grim picture of coerced consent, urging that images of empathic doctors using therapeutic technologies to help infertile women was a sham camouflaging experimental programs with low success rates. GENA COREA, THE MOTHER MACHINE: REPRODUCTIVE TECHNOLOGIES FROM ARTIFICIAL INSEMINATION TO ARTIFICIAL Wombs 170 (1979).
57 Hanmer asserted that infertile women’s determination to conceive indicated coercion and a desire to be wanted and needed. Jalna Hamner, A Womb of One’s Own, in TEST TUBE WOMEN: WHAT FUTURE FOR MOTHERHOOD? 445 (Rita Arditti, Renate Duelli Klein, and & Shelley Minden eds., 1984) (“women frequently believe they must have children to be ‘real’ and ‘full’ women because they are not valued as autonomous human beings but only as servicers to men, primarily as wives and mothers”). Others argued that infertile women need children to control and exhibit as trophies. PHYLLIS CHESLER, SACRED BOND: THE LEGACY OF BABY M 124 (1988). As Sultana Kamal questioned, “[d]oes not this obsessive craving to have a child of one's own in many cases stem from
perspective painted infertile women’s consent to ART as the inauthentic product of coercion, and thus of no real value. Many radical feminists even denied that a maternal instinct or drive to conceive exists.

For radical feminists, ART epitomized the patriarchal cultural and technological systems blamed for women’s historical and contemporary subordination, including the medicalization of childbirth, maternity, and appropriation of women’s reproductive capacities. Radical feminists also blamed ART for offering irresistible yet poisonous alternatives to infertile women. They intimated that infertile women, “blinded by science,” were not only ignorant of physiological side effects and political and social implications, but could not help themselves by declining further treatment. They viewed “the suffering of infertile women largely . . . in political and social terms,” prioritizing the opposition of institutionalized subordination and oppression, not ameliorating individual suffering. Instead, they urged infertile women to confront their pain, recognize its positive value, and use it for personal growth, proffering as a cure not conception but strong, deep, feminist consciousness-raising.

The radical feminist perspective, then, still viewed infertile women as somehow helpless, bodies in need of stronger voices shouting above the clamors of socio-cultural an individual’s sense of private property or the desire to have somebody around over whom one has substantial control for some years at least?” Sultana Kamal, Seizure of Reproductive Rights? A Discussion on Population Control in the Third World and the Emergence of the New Reproductive Technologies in the West, in MADE TO ORDER: THE MYTH OF REPRODUCTIVE AND GENETIC PROGRESS 153 (Patricia Spallone and Deborah Lynn Steinberg, eds., 1987).

60 Sandelowski, supra note 53, at 39.


63 See id. at 6-7; Klein, supra note 54, at 162.

64 Id. at 184 n. 4 (“If we want to be mothers and cannot, that may cause us great pain. But pain and suffering can sometimes have a positive value . . . . Actively dealing with our pain (rather than handing it over to the pharmacracy for a technological “fix”) can spur our growth. Our pain can impell [sic] us to look for more varied ways of living our lives fully.”)

pressures urging infertile women to conceive at all costs. If, borrowing the lyrics of Helen Reddy, a feminist boldly proclaims “I am Woman, hear me roar,”66 then the radical feminist vision of the infertile woman sniffled, “I am barren, hear me whimper.”67

B. Legal Portrayals of Women Considering Abortion

A brief glimpse of how pregnant women have been constructed as ineffective decision-makers in abortion jurisprudence informs our understandings of how and why legal scholars have rejected these depictions, offering in their stead representations of savvy and circumspect reproductive decision-makers.

1. The Pregnant Woman and the Abortion Decision in Supreme Court Jurisprudence

Constructions of pregnant women as poor reproductive decision-makers, unlike those of infertile women, originate in case law. Feminist legal scholars have staunchly opposed these characterizations. Depictions of women considering abortion in Supreme Court jurisprudence have morphed from Roe v. Wade’s68 circumspect rights-bearer who may obtain an abortion with only minimal physician consultation to the more cautious and emotionally vulnerable individual portrayed in Planned Parenthood v. Casey69 and Gonzales v. Carhart.70

Roe catalogues the stakes of denying women the choice to obtain an abortion, focusing not on the psychological difficulty of the abortion decision but on the mental, physical, and emotional burdens of raising an unwanted child.71 Roe conceptualizes the pregnant woman as subject to multiple burdens and harms, acknowledging the social, physical, and psychological hardships of childbearing and parenthood, and portrays the difficult abortion decision as a medical one to be made by a woman and her physician.72 Subsequent cases73 address the decision-making process more directly in terms of whether a woman’s consent to abortion can be “informed” by descriptions of pregnancy status; fetal development; dates of possible viability; physical and emotional complications from the abortion; risks of carrying the child to term; and the availability of agencies assisting with

67 Though its impact is now much weaker, radical opposition to ART has not disappeared altogether. Many of the same radical feminist writers on the front lines of ART opposition in the 1970s and 1980s still espouse the same arguments. Renate Klein, an editor of the ground-breaking volume Test-Tube Women, has emphasized that most, if not all, of radical feminists’ early concerns persist. TESTTUBE WOMEN: WHAT FUTURE FOR MOTHERHOOD? (Rita Arditti, Renate Klein, & Shelley Minden eds., 1984). Klein herself still argues that ART is “not only sexist, but racist, classist and deeply eugenic,” and warns of ART’s consequences in genetic engineering, commodification, “new” eugenics, globalization, low success rates; and health risks for women and IVF children. Klein, supra note 54, at 157-158.
71 Roe, 410 U.S. at 153.
72 Id.
birth control, adoption, and childbirth.\textsuperscript{74} Here, the abortion decision is seen as one that must be protected from others’ value judgments,\textsuperscript{75} and that primarily lies with the woman.\textsuperscript{76}

\textit{Planned Parenthood v. Casey} grants more flexibility to states to persuade pregnant women against abortion, a “unique act fraught with consequences for others.”\textsuperscript{77} The Court defines the constitutional question at issue as “whether the State can resolve these philosophic questions in such a definitive way that a woman lacks all choice in the matter.”\textsuperscript{78} Emphasizing that the abortion decision should be “thoughtful,” “informed,” “deliberate,” and made after a “period of reflection,”\textsuperscript{79} the majority asserts that the State may “provide a reasonable framework”\textsuperscript{80} to ensure that women accord this decision its due significance\textsuperscript{81} that may include providing certain information highly relevant to a “medical” decision to abort.\textsuperscript{82} Thus, although \textit{Casey} leaves a woman’s right to an abortion intact, it grants states more power to structure her decision-making process and persuade her not to exercise that right.

The most recent Supreme Court characterization of a woman’s decision to obtain an abortion is \textit{Gonzales v. Carhart}, in which the Court upholds the Partial-Birth Abortion Ban Act of 2003,\textsuperscript{83} a federal regulation prohibiting so-called “intact late-term” abortion procedures without an exception to preserve the mother’s health. The Court asserts that “[w]hether to have an abortion requires a difficult and painful moral decision,” one “fraught with emotional consequences.”\textsuperscript{84} Justice Kennedy controversially remarks that “[w]hile we find no reliable data to measure the phenomenon, it seems unexceptional to conclude some women come to regret their choice to abort the infant life they once created and sustained.”\textsuperscript{85} Therefore, he concludes,

The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.\textsuperscript{86}

The rationale undergirding \textit{Carhart} derives from “post-abortion syndrome” (PAS), a condition first proposed in the early 1980s by psychotherapist and counselor

\begin{itemize}
\item \textsuperscript{74} \textit{Thornburgh}, 476 U.S. at 764; \textit{Akron}, 462 U.S. at 445.
\item \textsuperscript{75} \textit{Id.} at 776-778.
\item \textsuperscript{76} \textit{Id.} at 781.
\item \textsuperscript{77} \textit{Casey}, 505 U.S. at 852.
\item \textsuperscript{78} \textit{Id.} at 850.
\item \textsuperscript{79} \textit{Id.} at 872, 885.
\item \textsuperscript{80} \textit{Id.} at 873.
\item \textsuperscript{81} \textit{Id.} at 872.
\item \textsuperscript{82} \textit{Id.} at 872, 882.
\item \textsuperscript{83} \textit{18 U.S.C.} § 1531 (2009).
\item \textsuperscript{84} \textit{Carhart}, 550 U.S. at 159.
\item \textsuperscript{85} \textit{Id.}
\item \textsuperscript{86} \textit{Id.} at 159-60.
\end{itemize}
Vincent Rue who claimed that abortion was psychologically distressing and led to feelings of guilt and other traumatic symptoms. Until the 1990s, the anti-abortion movement relied upon a fetal-protective platform, and PAS was perceived by most to detract from the fetal rescue mission. But by the early 1990s, facing public ire over clinic violence and abortion doctor murders, Bill Clinton’s election and the Supreme Court’s preservation of Roe in Planned Parenthood v. Casey, abortion opponents began to view PAS as an ideal argument for reaching audiences concerned with women’s rights and welfare.

It was then that PAS, “a therapeutic discourse concerned with informing women’s decision-making about abortion, [was transformed] into [the] woman-protective antiabortion argument (WPAA), a political discourse that seeks to persuade voters who ambivalently support abortion rights that they can help women by imposing legal restrictions on women's access to abortion.”

WPAA principles are evident in both case law and legislative regulations. Legal scholars have suggested that Carhart replaces Casey’s reliance on a “woman's dignity and autonomous choice” rationale with a “women’s regret” argument. Under Carhart, regulation is necessary to protect a woman who is misled by her physicians, unaware of her own “natural” maternal instincts, and ignorant of abortion’s consequences. Notably, the stereotype of the pregnant woman who aborts incorporates not only stupidity and irrationality, but also unnecessary risk-taking and careless decision-making. Representative Dick Armey once stated that providing abortion services as part of the national health care package would “‘condone the self-indulgent conduct of the body of a woman who has already demonstrated’ that she was ‘damned careless with it in the first place.’”

The WPAA has most recently found fertile ground in South Dakota, where a legislative task force report entitled “Report of the South Dakota Task Force to Study Abortion” greatly influenced the enactment of the Women’s Health and Human Life Protection Act. This Act, passed in March 2006 as a blatant attempt to overturn Roe, was repealed on November 7, 2006 by a citizen referendum. It outlawed most forms of abortion, including for rape and incest, but preserved an exception to save the pregnant woman.

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89 Turner, supra note 87, at 21; Siegel, supra note 88, at 1658.
90 Siegel, supra note 88, at 1659-1662.
91 Id. at 1666-1669.
92 Id. at 1669.; Turner, supra note 87, at 21.
93 Turner, supra note 87, at 21.
96 Id. at 1902-3.
woman’s life.\textsuperscript{99} The task force report itself concludes that the “unborn child” is a full human being from conception, that doctors are obliged to treat both pregnant women and their fetuses as patients, that abortion terminates the unique and important fetal-maternal bond, and that abortion counseling does not inform women that their children already exist.\textsuperscript{100} The task force majority avers that women can \textit{never} make an \textit{informed} choice to abort “because a pregnant woman cannot make a truly informed decision to give up a relationship with a child until after the child is born.”\textsuperscript{101} Despite the defeat of the Women’s Health and Human Life Protection Act, its history demonstrates the strength and appeal of WPAAs to contemporary audiences.\textsuperscript{102}

Such arguments may also be found in the work of anti-choice scholars such as David Reardon. For Reardon, abortion is “overwhelming, especially for women who are immature or emotionally unstable.”\textsuperscript{103} He has asserted that “many women fundamentally do not want an abortion” but are pushed into it by social, situational, and personal pressures, even against “maternal desire.”\textsuperscript{104} Finally, Reardon has opined that women considering abortion are unaware that “there is no medical evidence that abortion will actually produce the benefits they desire,”\textsuperscript{105} and that concealing information about the fetus or pregnancy from them reinforces “a paternalistic view of fragile pregnant women who simply cannot handle the full truth about all the possible implications of their pregnancy options.”\textsuperscript{106}

\textbf{2. Feminist Legal Scholars React to Woman-Protective Rationales}

Writing from a very different ideological position, feminist legal scholars have vehemently opposed the Supreme Court’s use of woman-protective rationales in abortion jurisprudence. Their objections parallel Justice Ginsburg’s dissent in \textit{Carhart}. Justice Ginsburg strenuously objects to the majority’s cavalier and intuitive means of deciding that regret is a frequent byproduct of a woman’s decision to abort, terming it an “antiabortion shibboleth.”\textsuperscript{107} While she agrees that “for most women, abortion is a painfully difficult decision,” Justice Ginsburg disagrees with the majority’s ruminations on “women’s fragile emotional state” and accuses it of “depriv[ing] women of the right to make an autonomous

\begin{itemize}
\item \textsuperscript{99} Women’s Health and Human Life Protection Act, HB1215 § 1.
\item \textsuperscript{100} \textit{SOUTH DAKOTA TASK FORCE TO STUDY ABORTION, REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION} 10, 13, 14, 55 (December 2005).
\item \textsuperscript{102} Siegel argues that this argument “has spread throughout the antiabortion movement”—“several leading antiabortion organizations feature it as a primary argument against the availability of abortion . . . Other antiabortion organizations feature the harm-to-women argument as one among many abortion-related concerns. . . . Several states, including Ohio, Mississippi, and Louisiana have followed in South Dakota’s footsteps, including the use of the harm-to-women language in legislative findings or testimony.” Reva B. Siegel, \textit{Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression}, 56 EMORY L. J. 815, 835 n. 68 (2007).
\item \textsuperscript{104} \textit{Id.} at 65-66.
\item \textsuperscript{105} \textit{Id.} at 61-62.
\item \textsuperscript{106} \textit{Id.} at 55.
\item \textsuperscript{107} \textit{Carhart}, 550 U.S. at 183.
\end{itemize}
choice," arguing that no evidence suggests that "having an abortion is any more dangerous to a woman's long-term mental health than delivering and parenting a child that she did not intend to have."108 It would be more appropriate, she asserts, to "require doctors to inform women, accurately and adequately, of the different procedures and their attendant risks."109 Justice Ginsburg, then, thoroughly repudiates the majority's view that the partial-birth abortion ban protects women, stating that "[e]liminating or reducing women's reproductive choices is manifestly not a means of protecting them."110

Like Justice Ginsburg, feminist legal scholars object to WPAA assumptions that women are naturally predisposed towards motherhood and bonding, that they are unaware of a maternal bond or that they can carry their children to term, that women cannot understand abortion's risks and benefits and rationally choose between them, that doctors do not want to assist women to make responsible choices, and that a woman choosing abortion is not to blame for resulting emotional or physical harm.111 These scholars fault these assumptions for pathologizing women's decisions to abort as "confused, misled, or coerced," or abnormal.112 Women who abort are always pathological under WPAA tenets; a pregnant woman who feels a maternal bond but aborts her pregnancy is traumatized by the procedure, and a woman who does not feel a bond and aborts is traumatized by her aberrant non-maternal nature.113 Similarly, according to the WPAA, obtaining an abortion is inherently unnatural because it is both a non-maternal and non-procreative act.114

The WPAA as a "one-size-fits-all cure" has also garnered criticism as portraying all women as mentally ill, and encompassing all pregnant women rather than offering social services to particular groups likely to suffer psychological distress.115 Feminist legal scholars argue that the needs of some emotionally vulnerable women should not dictate paternalistic reproductive policies for all.116 What is needed is not a blanket abortion restriction but rather a method for identifying and aiding pregnant women who are actually in mental or emotional distress.117

Feminist legal scholars have also extensively criticized portrayals of confused, uninformed and weak-willed pregnant woman inhabiting Supreme Court jurisprudence. Elizabeth Reilly argues that pregnant women have been portrayed as victims since Roe, at

108 Id. at 184, 184 n. 7.
109 Id. at 184.
110 Id. at 184 n. 9.
111 Ivey, supra note 94, at 1491.
112 Siegel, supra note 88, at 1686.
113 Ivey, supra note 94, at 1499.
114 Id. at 1500.
115 Id. at 1688.
116 See, e.g., Siegel, supra note 101, at 1033 ("Some individual men and women may make decisions in an agitated mental state, and targeted support and safeguards for them may be needed, but to regulate on the presupposition that agents are generally in this condition is to presume decision-makers incapable of acting sui juris, hence requiring paternalistic oversight").
117 Reva B. Siegel, Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart, 117 YALE L.J. 1694, 1796 (2008) ("Blanket restrictions on abortion . . . violate the dignity of women who are fully competent to make decisions, and do absolutely nothing to help women who are subject to coercion or mental confusion, or to alter the pressures on women who have decided ending a pregnancy is the best choice under the life circumstances and institutional arrangements in which they find themselves.").
the mercy of pregnancy, enforced childbirth and parenthood, and as patients who must consult with their physicians before acting.\textsuperscript{118} She observes that, in case law, pregnant women portrayed as victims are better able to attain access to abortion, but pregnant women portrayed as powerful and who exercise autonomy and agency encounter restricted access to abortion.\textsuperscript{119} The image of the pregnant women in Supreme Court jurisprudence is but a “caricature” who is “capable of the responsibility of motherhood, but not of the full moral responsibility demanded by . . . procreative choices.”\textsuperscript{120} The stereotypical portrayal of pregnant women is of “victims of emotion; they make bad decisions in a crisis, they are prone to panic, and they are easily manipulated by unscrupulous doctors, who apparently have nothing better to do than trick women into having abortions that they would not have if they were thinking properly.”\textsuperscript{121} Dresser, for one, has rejected this “psychological vulnerability” as unsupported.\textsuperscript{122} Scholars contend that women are actually astute predictors and mediators of their emotional states, anticipating and indeed overestimating regret, and that women make the decision to obtain abortions “within a web of interlocking, competing, and often irreconcilable responsibilities and commitments.”\textsuperscript{123}

Furthermore, feminist legal scholars have commented on both the differential treatment of pregnant women compared to women needing other medical attention, and the differential treatment of pregnant women seeking to abort compared to those seeking to carry to term. They note that women considering abortion do not receive the respect accorded other patients,\textsuperscript{124} as shown through the abortion counseling and waiting period requirements.\textsuperscript{125} They protest that women, whether pregnant or not, are considered capable of making other medical decisions in other contexts that are not burdened with ideological and moral baggage.\textsuperscript{126} Moreover, they assert, pregnant women who do not seek abortion

\textsuperscript{118} Elizabeth Reilly, The “Jurisprudence of Doubt:” How the Premises of the Supreme Court’s Abortion Jurisprudence Undermine Procreative Liberty, J.L. & POL. 771 (1998). \textit{See also} Ivey, \textit{supra} note 94, at 1481-83 (discussing how the Supreme Court has applied WPAA’s logic in decision from \textit{Roe} to \textit{Gonzales}).

\textsuperscript{119} Reilly, \textit{supra} note 118, at 771-72.

\textsuperscript{120} \textit{Id.} at 790.


\textsuperscript{125} Gans, \textit{supra} note 95, at 1903.

\textsuperscript{126} \textit{Id.}
are not exposed to informed consent materials and required to wait a statutorily specified time period before electing to continue their pregnancies.\textsuperscript{127}

Another frequent scholarly criticism of the WPAA is paternalism. Legal scholars have repeatedly emphasized that WPAA principles degrade women and their powers of physical and moral reasoning. The WPAA embodies the chauvinistic idea that women are the property of men and that others are entitled to use their bodies as means to social or moral ends.\textsuperscript{128} Paternalism also results from viewing female reproductive capacity as “of concern to others” besides the woman herself.\textsuperscript{129} WPAA legitimates “anxiety” over female reproduction and female agency, enabling legal regulation.\textsuperscript{130} Such paternalistic assumptions offend women’s bodily integrity, damage women’s identity and self-esteem,\textsuperscript{131} and reduce women to their wombs.\textsuperscript{132} Affirming a pregnant woman’s decision-making capacity is to oppose paternalism\textsuperscript{133} and to affirm feminine autonomy and control and therefore feminine dignity.\textsuperscript{134}

C. Why Do These Tensions Exist?

Legal scholars’ constructions of infertile women undergoing IVF are in strong tension with constructions of women considering abortion, despite the fact that in both contexts women are making reproductive decisions. Allowing these constructions to coexist makes little sense, and is tantamount to saying that women become overwrought when seeking fertility treatment but not abortion. Effectively countering protectionist arguments requires first answering the question, “Why do scholars continue to embrace decision-making protectionism for infertile women while rejecting it for pregnant women considering abortion?”

Scholars writing on ART might be using the desperate women stereotype to effect legal change. The differences between these constructions do not merely indicate that two conflicting portraits of women as reproductive decision-makers are in awkward coexistence. While contemporary abortion scholarship portrays women as competent

\textsuperscript{127} Id. (“If a woman comes to an abortion clinic and tells the clinic staff that she wants to carry her child to term, the state does not force the woman to return home and rethink her decision.”).
\textsuperscript{130} Id.
\textsuperscript{131} See Julia E. Hanigsberg, Homologizing Pregnancy and Motherhood: A Consideration of Abortion, 94 Mich. L. Rev. 371, 371-72, 382-83 (1995) ("By interfering in unique ways with women's bodily integrity in the guise of regulation of procreative decision-making, law both facilitates and justifies that violation of bodily integrity. Because bodily integrity is necessary for the formation of selfhood, it is essential that law recognize women's subjectivity in its construction of women's procreative lives").
\textsuperscript{132} Id. at 417.
\textsuperscript{133} Id. ("The meaning that women ascribe to their abortions, to their mothering decisions, and to intrauterine life is crucial to this legal process. Any legal construction that keeps women from making these decisions will reaffirm procreativity as the object of male domination.").
\textsuperscript{134} Siegel, supra note 102, at 818-819.
decision-makers, historically scholars emphasized women’s vulnerability and desperation, using the dramatic portrait of the desperate pregnant woman to highlight the dangers of back-alley abortions, unsanitary conditions, and unscrupulous and unlicensed providers. After abortion was legalized, scholars’ abortion arguments changed, focusing on what obstacles a state could legitimately place in women’s paths, and their portrayals of pregnant women have accordingly evolved from a desperate woman into one who is a circumspect and competent reproductive decision maker.

But in the ART context, women seeking fertility treatment do not face the same obstacles they must overcome in obtaining abortions. Scholars might actually be using the desperate woman stereotype to demonstrate the need for restrictions on ART services, not to create unflattering stereotypes. For instance, desperation might provide a woman with an argument as to why she should be able to avoid ART documents that are allegedly contracts of adhesion.

Another apparent reason why liberal feminist scholars have not yet addressed this issue is not willful ignorance but the altogether understandable rationale that constructions of infertile women have historically posed a lesser threat than constructions of women considering abortion. Addressing scholarly images of infertile women has taken place on the level of narrative construction, not on that of legal doctrine. Unlike abortion, which is at the heart of constitutional jurisprudence and privacy discourse, stereotypes of infertile women have not been the basis of legal regulation. The abortion debate, however, came to

135 See Richard Delgado & Judith Droz Keyes, Selective Abortion: A Commentary on Roe v. Wade, Doe v. Bolton, and the Shape of Things to Come, 1974 WASH. U. L. Q. 203, 224 n. 115 (1974) (stating that “restrictive abortion laws drove “large numbers of desperate women into the hands of the very person from whom the law seeks to shield them . . . ”); Ruth Roemer, The Right to Choose Abortion, 64 AM. J. OF PUB. HEALTH 821 (1974) (characterizing the pre-Roe period as a time when “dangerous, illegal abortion was the sole solution for desperate women faced with unwanted pregnancies”); Andrea Dworkin, Abortion, 1 LAW & INEQ. 95 (1983) (describing “doctors who were asked for “help” by desperate women”); Lynn Wardle, Rethinking Roe v. Wade, 1985 BYU L. REV. 221, 249 (1985) (referring to “invidious laws that were forcing desperate women to seek the radical remedy of abortion”); “Brief for the Amici Curiae Woman who have had Abortions and Friends of Amici Curiae in support of Appellees, at B1-B92, Webster v. Reproductive Health Services, 109 S.Ct. 3040 (1989) (women describing their experiences with illegal abortions and characterizing themselves as desperate and vulnerable). Margie Ripper, Abortion: The Shift in Stigmatisation From Those Seeking Abortion To Those Providing It, 10 HEALTH SOC. REV. 65, 66 (2001) (noting that “in the public debates surrounding the reforms, the stereotypic ‘backyard abortionist’ was commonly invoked as being not medically trained, uncaring, unclean, unscrupulous, and ‘taking advantage’ of desperate women.”). Images of desperate women seeking abortions still populate areas of abortion scholarship where greater abortion access is sought for certain groups, such as minors. See, e.g., Brian Z. Tamanaha, Good Casuistry and Bad Casuistry: Resolving the Dilemmas Faced by Catholic Judges, 4 U. ST. THOMAS L.J. 269 (2006) (stating that “a desperate minor may even feel compelled to seek an underground abortion . . . ”).

136 See infra notes 121-126.

137 Sarah D. Peterson, Dealing With Cryopreserved Embryos Upon Divorce: A Contractual Approach Aimed at Preserving Party Expectations, 50 UCLA L. REV. 1065, 1089 (2003) (discussing scholars who view written consent forms provided by infertility clinics as adhesion contracts); Coleman, supra note 21, at 104 (stating that “the contractual approach turns the couple's most personal decisions about how their reproductive capacity will be used into a nonnegotiable clause in a contract of adhesion”); John Robertson, In the Beginning: The Legal Status of Early Embryos, 76 VA. L. REV. 437, 465 (1990).
a head in the 1980s, when states enacted legislation limited access and decision-making. Only recently have threats to reproductive autonomy arisen in the infertility context.

A host of other reasons may underlie scholars’ odd adherence to protectionism. Legal scholars may be uncomfortable with the commodification of reproduction.138 Certainly there are people who make money in the ART business. Relatedly, there may be less motivation to come to the aid of wealthy, educated women than to assist women in trouble who seek abortions, particularly when stereotypes portray infertility as the “yuppie woman’s disease” and infertile women as rich, spoiled and voluntarily delaying childbirth in favor of career or education.139 It may be that infertile women have apparently viable alternatives such as adoption.140 Notwithstanding all of these justifications, protectionist constructions of infertile women are inaccurate and unnecessary evils. Such demeaning constructions scar the discursive topography of meta-narrative concerning women and child-rearing, rendering its landscape ugly.

One final explanation might be that some legal scholars may view such protectionist measures as necessary to promote a feminist agenda of autonomy. In a sense, abortion is a much easier case for feminists—women who obtain abortions are defying patriarchal establishments while women undergoing infertility treatment seem to be complying with them. Whereas women have not been socially conditioned to have abortions, they have been conditioned to desire physical motherhood, so women seeking to conceive are ostensibly in need of more protection against the dominant culture.141

II. COMMON MISCONCEPTIONS: WHY CONSTRUCTIONS OF INFERTILE WOMEN ARE INACCURATE

Legal scholars’ constructions of infertile women not only contradict other more pervasive and empowering constructions of women considering abortion, but they also conflict with clinical psychological and psychiatric research addressing the link between infertility and emotional distress, with normative arguments that ART expands women’s reproductive choices and that women can freely chose to have children, and with empirical research on the constructive roles that emotion can play in medical and reproductive decision-making.

139 See Margaret Ann Mille, The Fertility Center of Sarasota is One of About 350 Clinics Nationwide Using Technology to Help Women Have Babies: In-vitro Specialists Beget a Fertile Business, SARASOTA HERALD-TRIBUNE, Oct. 23, 2000, Business Weekly Section, at 1. Elizabeth Stern, the intended mother in the infamous surrogacy case In Re Baby M, was described as a career woman, and not as a mother. PHYLLIS CHESLER, SACRED BOND: THE LEGACY OF BABY M 23 (1988). See also MARDY S. IRELAND, RECONCEIVING WOMEN: SEPARATING MOTHERHOOD FROM FEMALE IDENTITY 8 (1993) (describing the stereotype as “a socially isolated, career-driven woman consumed by a fatal jealousy and envy of motherhood and the nuclear family.”)
140 This rationale is frequently advanced by courts awarding frozen pre-embryos to the party who does not want to become a genetic parent in divorce disputes. See, e.g., Kass v. Kass, 235 A.2d 150, 167 (1977); Davis v. Davis, 842 S.W.2d 588, 604 (Tenn. 1992).
141 See infra notes 51-65.
A. The Teachings of Clinical Research

The assumption that infertile women’s emotional excesses and desperation to conceive is abnormal and irrational originates in both centuries-old scientific and medical theories of hysteria and repronormativity. For centuries, female emotional excesses have been seen as manifestations of hysteria. The ancients believed that “disordered sexuality” was related to emotional instability, and proposed that the womb was a restless and dissatisfied organ that sometimes wandered off, causing physiological mayhem. The prescribed remedy was to marry the suffering woman off so that the uterus could become grounded with a child. By the seventeenth century, physicians no longer believed in the uterus with wanderlust, but theorized that uterine vapors interacted with other organs. By the eighteenth century the focus was on the brain itself, and hysteria became a disorder of the nervous system. In the nineteenth century, Sigmund Freud proposed that hysteria was rooted in histories of trauma. Hybrid neurouterine theories continued to emerge into the nineteenth century. Whatever its origins, hysteric behaviors remained the same: “highly negative character traits, including eccentricity, impulsiveness, emotionality, coquettishness, deceitfulness, and hypersexuality.” Nervous hysterical disorders were blamed for genteel infertility as well as miscarriage and abortion. As it gained recognition as a nervous disorder, hysteria also became affiliated with a certain type of women—idle, delicate, and melancholic genteel white women.

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142 This stereotype is not new; the idea that “women are naturally maternal, but not naturally rational” can be linked to Victorian obstetrics and historical images of hysterical women. Rebecca E. Ivey, supra note 94, at 1493, 1499; Siegel, supra note 101, at 1032-33. Other scholars have documented the effects of feminism on law. See generally Jeannie Suk, The Trajectory of Trauma: Bodies and Minds of Abortion Discourse, 110 COLUM. L. REV. 1193 (2010).
143 Elisabeth Bronfen, The Knotted Subject: Hysteria and Its Discontents 182 (1998). Phillip R. Slavney, Perspectives on “Hysteria” 18 (1990); Gabrielle Murphy, Hysteria’s Story: History or Legend?, 135 LANCET 1806 (1999). See also Bronfen, supra note 143, at 105 (stating that the Hippocratic perspective on hysteria believed it was caused by “the peregrinations of a restless, dissatisfied womb.”).
144 See Bronfen, supra note 143.
146 Murphy, supra note 143, at 1806; Donald Capps, Jesus the Village Psychiatrist 110 (2008).
147 Bronfen, supra note 143, at 108.
148 Id. at 111.
149 Murphy, supra note 143, at 1806.
150 Capps, supra note 146, at 110.
151 Id.
153 Bronfen, supra note 143, at 111. The hysterical ideal was a “delicate and highly sensitive woman who suffers convulsions at the vivid description of a tragic event or faints at the slightest onset of pain.” Id. at 113. After conducting a reading of late-nineteenth century American Journal of Obstetrics articles, Laura Briggs concluded that “its physician-contributors understood and deployed [gendered] distinctions extensively, characterizing white women as weak, frail, and nervous . . . .” Briggs, supra note 152, at 247, 254. See also Slavney, supra note 142, at 18. Hysterical women were considered subconsciously self-absorbed and therefore frail. Bronfen, supra note 143, at 110, 114-15.
With the advent of new opportunities for women, hysteria acquired hegemonic socio-cultural dimensions and proved useful for ostracizing “unnatural” women who sought education, equality, and employment outside of the home. From the “shriveling ovaries of educated women” to Harvard President Edward Clarke’s 1873 remark opposing women’s education because the “blood demanded by the brain would prevent the reproductive system from developing properly,” opposition to increased public roles for women was legitimized through medical research, and hysteria became “a warning about the dangerous consequences for women of engaging in “unfeminine” behavior.”

Contemporary clinical literature, being positive rather than normative, has very different characterizations of infertile women. Research diverges on whether there is a consistent link between infertility and emotional disorders such as clinical depression. To the extent that the clinical literature correlates infertility with anxiety, stress, emotion and determination, even depression or desperation, it does not necessarily show a deterioration in judgment, an inability to weigh choices appropriately, or a lack of decision-making capacity that would vitiate informed consent.

Clinical research substantiates legal scholars’ observations that infertile women are determined to conceive. Clinicians observe that infertility “becomes the focal point of daily discourses and tasks” for infertile women, even becoming their “sole focus,” and note that women are willing to try any “viable” treatment, even with a potential increased risk of ovarian cancer. They do not conclude, however, that for infertile women a perceived loss of control stemming from infertility is equivalent to an actual loss of self-control.

Legal scholars frequently describe infertile women as irrational for electing to undergo a procedure with such “low odds” of success. However, clinical statistics show that the chances of successfully conceiving are much higher than legal scholars claim, making the choice more reasonable. In 2007, women 35 and younger enjoyed a 45.7 percent likelihood of becoming pregnant through IVF without donor eggs, as did 37.2 percent of women 35 to 37; although pregnancy rates for older women were lower (28.1

154 As Laura Briggs has asserted, “[l]ate nineteenth-century gynecological and obstetrical literature . . . naturaliz[ed] opposition to white women’s political struggles by insisting that contraceptive use, abortion, education, and participation in the professional workforce could cause nervous illness.” Briggs, supra note 152, at 248, 250. Such “unnatural” women were even thought by some to be racial traitors who endangered the white race through their low fertility. Id. at 246-47.
155 Id. at 248. See generally BARBARA EHRENREICH & DEIRDRE ENGLISH, COMPLAINTS AND DISORDERS: THE SEXUAL POLITICS OF SICKNESS (1973); BARBARA EHRENREICH & DEIRDRE ENGLISH, FOR HER OWN GOOD: 150 YEARS OF THE EXPERTS’ ADVICE TO WOMEN (1978).
157 Id. at 296.
percent for women 38 to 40, and 18.4 percent for women 41-42). 55.1 percent of IVF cycles using fresh donor eggs resulted in a live birth for all ages combined.161

Clinical research also undermines legal scholars’ contentions that infertile women are not circumspect and strategic ART consumers. Infertile women strive to play an active role in reproductive decision-making and report conducting copious research on infertility and treatment choices.162 After conducting open-ended interviews with infertile couples undergoing IVF, Sandelowski et al. notes that, after deciding to seek medical treatment, infertile couples “engaged in as rational an accounting process as they could and weighed the options known and accessible to them” before evolving a strategic “calculus of pursuit . . . of resources, of venture capital including time, money, and physical and psychic energy and then . . . determined whether to pursue it at a given time.”163

Clinical research does acknowledge that infertility is emotionally distressing. Identified psychological responses to infertility include surprise, denial, anxiety, anger, guilt, poor self-image or decreased self-esteem, isolation, distrust of one’s body, loss of bodily integrity and privacy, overgeneralization of loss of control over reproduction to other aspects of life, hopelessness, feelings of unfulfillment, inability to plan for the future, compromised ability to find alternate goals and meaning in life, social withdrawal, and depression.164 Many researchers have found that most infertility patients, particularly women, find infertility and its treatment to be “the most upsetting experience of their lives.”165 An infertility diagnosis is often described as an intangible loss that triggers cyclical166 grieving like that from a loved one’s death.167 It involves multiple losses: pregnancy, childbirth, and breastfeeding; a sense of genetic continuity, experiences of parenthood and relationships, and a key element of adult and gender identity.168 Infertility

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163 Sandelowski et al., supra note 159, at 223.
165 Domar & Cousineau, supra note 156, at 294-5.
167 See The Psychological Impact of Infertility and Its Treatment, HARV. MENTAL HEALTH LETTER (May 1, 2009).
Clinicians have a more nuanced understanding of infertility’s unique emotional impact upon women. Its effects are more pronounced on women than on men; women are more likely to experience lower self-esteem and life-satisfaction and increased self-blame and greater psychological distress, and find it harder to leave behind the biological parenthood ideal.\textsuperscript{170} Women must carry the burden of infertility diagnosis whether they themselves are infertile or infertile by association; they undergo the most monitoring, invasive treatments, pain, medication side effects, and schedule disruptions.\textsuperscript{171} Research also suggests that infertile women experience infertility as a chronic disease, experiencing levels of depression and anxiety indistinguishable from those of women with cancer, hypertension, myocardial infarction, or HIV, and differing only from chronic pain patients.\textsuperscript{172} The treatment of infertility is, after all, like that of a chronic illness, entailing extensive medical appointments, testing, medication, surgical intervention, pain, drug side effects, fear, grief, and psychological identity adjustment.\textsuperscript{173}

But while studies substantiate a link between infertility and distress, they do not correlate distress to incapacity, equate desperation to clinical depression. Research differs as to how strongly depression is tied to infertility, with some studies supporting a link.\textsuperscript{174}

\textsuperscript{169} Domar & Cousineau, supra note 156, at 296.
\textsuperscript{170} Id. (stating that infertility can challenge the “core female identity” leading to diminished self-worth). See also Schmidt, supra note 164, at 379; Cooper & Glazer, supra note 164, at 17-19; Judith C. Daniluk, Infertility: Intrapersonal and Interpersonal Impact, 49 Fertility & Sterility 988 (1988).
\textsuperscript{171} Domar & Cousineau, supra note 156, at 296 (stating that women are the “identified patient” who undergoes invasive procedures, monitoring, and scheduling disruption).
\textsuperscript{172} See generally Alice D. Domar, Patricia C. Zuttermeister & Richard Friedman, The Psychological Impact of Infertility: A Comparison to Patients with Other Medical Conditions, 14 J. Psychosomatic Obstetrics & Gynaecology 45-52 (1993).
\textsuperscript{173} Bridwell, supra note 166, at 94-95, 129, 146.
\textsuperscript{174} Numerous studies suggest that anxiety and depression are the most common reactions to infertility treatment, or conclude that infertile women have significantly higher levels of depressive symptoms than in the general population and even twice or three times more than fertile women. A. Eugster & A.J.J.M. Vingerhoest, Psychological Aspects of In Vitro Fertilization: A Review, 48 Soc. Sci. & Med 575-589 (1999) (literature review finding that anxiety and depression are the most common reactions to treatment); C.H. Garner, E.W. Arnold & H.Gray, The Psychological Impact of In Vitro Fertilization, 41 Fertility & Sterility 28 (1984) (concluding that 64 percent of women undergoing IVF reported significant depressive symptoms as measured by the Beck Depression Inventory after an unsuccessful IVF cycle); J. Wright, F. Bissonnette, C. Duchesne et al., Psychological Distress and Infertility: Men and Women Respond Differently, 55 Fertility & Sterility 100-108 (1991) (finding that infertile women had higher levels of depressive symptoms); T.H. Chen, S.P. Chang, C.F. Tsai & K.D. Juang, Prevalence of Depression and Anxiety Disorders in an Assisted Reproductive Technique Clinic, 19 Human Reproduction 2313 (2004) (finding infertile women had higher depressive symptoms than in the general population); J. Cwikel, Y. Gidron & Sheiner, Psychological Interactions with Infertility Among Women, 117 Eur. J. Obstetrics, Gynaecology, & Reprod. Biology 126-131 (2004); Alice D. Domar, P.C. Zuttermeister, M. Seibel & H. Benson, Psychological Improvement in Infertile Women After Behavioral Treatment: A Replication, 38 Fertility & Sterility 144-147 (1992); J. Downey & M. McKinney, The Psychiatric Status of Females Presenting For Infertility Evaluation, 62 Am. J. Orthopsychiatry 196-205 (1992) (finding that 11% of infertile women satisfied criteria for a major depressive episode, as compared with 3.9%
and others concluding that no correlation exists. Although there is disagreement as to whether infertility is correlated with clinically significant or pathological levels of distress, of fertile women); Alice D. Domar, A. Broome, Patricia C. Zuttermeister, M.M. Seibel, and Richard Friedman, *The Prevalence and Predictability of Depression in Infertile Women*, 58 FERTILITY & STERILITY 1158-1163 (1992) (finding that 36 percent of infertile women scored above normal on the Beck Depression Inventory as compared to 18 percent of fertile women, with 6.4 percent experiencing symptoms in the severe to extremely severe range). The stage and form of infertility diagnosis seems to affect psychological distress; definitive diagnoses of infertility produce significantly higher depression scores than unexplained or undiagnosed infertility, and patients undergoing infertility-related surgery have significantly higher depression scores than those who did not. *Id.* at 1162. Women undergoing IVF, however, may not exhibit higher levels of grief and depression than women undergoing artificial insemination. Michelle P. Lukse & Nicholas A. Vacc, Grief Depression, and Coping in Women Undergoing Infertility Treatment, 93 OBSTETRICS & GYNECOLOGY 249 (1999) (56 percent of IVF patients and 58 percent of patients who took ovulation-induction medication prior to artificial insemination reported feelings of depression before beginning treatment, while 62 percent of IVF and 68 percent of ovulation-induction medication subjects reported feelings of depression four weeks after a negative pregnancy test).

Other sources conclude, however, that anxiety, depression, and other mental health disorders are not greater among infertile women than in the general population; as a 2009 WHO report states, “a number of cohort comparison studies . . . have found no significant difference in rates of psychiatric illness, other psychopathology or personality factors” between infertile groups and fertile groups, the general population, or between groups “with infertility of different origin and duration.” *The Psychological Impact of Infertility and Its Treatment*, supra note 167; *World Health Org., Mental Health Aspects of Women’s Reproductive Health: A Global Review of the Literature* 130 (2009), available at http://whqlibdoc.who.int/publications/2009/9789241563567_eng.pdf; R.J. Edelmann et al., Psychogenic Infertility: Some Findings, 12 J. OF PSYCHOSOMATIC OBSTETRICS AND GYNAECOLOGY 163-168 (1991); A.P. Visser et al, Psychosocial Aspects of In Vitro Fertilization, 15 J. OF PSYCHOSOMATIC OBSTETRICS AND GYNAECOLOGY 35-43 (1994). Literature reviews have also found no consistent relationship between infertility and emotional distress, and numerous studies conclude that most infertile women do not have clinical depression but may experience mood changes and lower self-worth. Dunkel-Schetter & M. Lobel, Psychological Reactions to Infertility, in INFERTILITY: PERSPECTIVES FROM STRESS AND COPING RESEARCH 29-57 (A. Stanton & C. Dunkel-Schetter eds., 1991); A. Stanton & S. Danoff-Burg, Selected Issues in Women’s Reproductive Health: Psychological Perspectives, in THE PSYCHOLOGY OF WOMEN’S HEALTH 261-305 (A. Stanton & S. Gallant eds., 1995); D. Brasile, B. Katsoff & J.H. Check, Moderate or Severe Depression is Uncommon in Women Seeking Infertility Therapy According to the Beck Depression Inventory, 33 CLINICAL & EXPERIMENTAL OBSTETRICS & GYNECOLOGY 17 (2006); J. Downey, S. Yingling, M. McKinney, N. Husami, R. Jewelewicz & J. Maidman, Mood Disorders, Psychiatric Symptoms, and Distress in Women Presenting for An Infertility Evaluation, 52 FERTILITY & STERILITY 425-432 (1989) (finding no difference in psychiatric symptoms, measures of self-esteem and sexual functioning, or the percentage of infertile women versus controls experiencing a current or past episode of major depressive disorder); J.D. Paulson, B.S. Haarmann, R.L. Salerno & P. Asmar, An Investigation of the Relationship Between Emotional Maladjustment and Infertility, 49 FERTILITY & STERILITY 258-262 (1988) (finding that “significant emotional maladjustment” is no worse for infertile women than for fertile women.”); M.T. Hearn, A.A. Yuzpe, S.E. Brown & R.F. Casper, Psychological Characteristics of In Vitro Fertilization Participants, 156 AM. J. OF OBSTETRIC GYNECOLOGY 269-274 (1987) (finding that couples undergoing IVF reported good quality of life and no depression and anxiety). Failure to observe clinical anxiety or depression symptoms, however, does not indicate that infertility patients experience no psychological distress; degrees of distress are observed during treatment phases, in particular lowered self-esteem and heightened guilt and self-blame as compared to fertile persons. Daniluk, supra note 170, at 988; see also J. Beaurepaire, et al., Psychosocial Adjustment to Infertility and Its Treatment: Male and Female Responses at Different Stages of IVF/ ET Treatment, 38 J. OF PSYCHOSOMATIC RES. 229-240 (1994); Nachtigall, Becker &
clinical researchers do agree that emotional distress is most likely to occur subsequent to a
treatment cycle—after informed consent and embryo disposition forms are signed, and in
particular after multiple failed treatment cycles. In addition, emphasis is placed upon
depression, not upon the frantic and endless pursuit of pregnancy that terms such as
“desperation” and “obsession” imply.

Specifically, studies show that an infertile individual’s mental health correlates to
both infertility and treatment experiences. Many IVF patients experience depressive
symptoms before an IVF cycle, particularly if they have experienced multiple unsuccessful
rounds. These symptoms, however, stem from patient apprehension over treatment
outcome and not the procedures themselves. Many other medical patients hope for a
cure and experience pre-treatment anxiety, yet we would not say that these worries
undermine their ability to give informed consent to that procedure. A failed IVF cycle is
more likely to contribute to increased anxiety and depression, with levels increasing over
the time that treatment is unsuccessful. The consensus is that emotional strain increases
over the first two years of treatment, peaking around year three. Thus, legal scholars

Wizny, supra note 168, at 113-121; Edelmann et al., supra note 175, at 163-168; V.J. Callan & J.F.
Hennessey, The Psychological Adjustment of Women Experiencing Infertility, 61 BRITISH J. OF MED.
PSYCHOL. 137-140 (1988); K.A. Morrow, R.W. Thoreson & L.L. Penney, Predictors of Psychological
Distress Among Infertility Clinic Patients, 63 J. OF CONSULTING AND CLINICAL PSYCHOL. 163-167
(1995); J. Bernstein, N. Potts & J.H. Mattox, Assessment of Psychological Dysfunction Associated

176 See, e.g., C.H. Garner, E.W. Arnold, & H.Gray, The Psychological Impact of In-Vitro

177 The Psychological Impact of Infertility and Its Treatment, supra note 167. For instance, one study
concluded that women who were unable to conceive in the first six months had significantly higher
levels of anxiety and depressive symptoms, poorer marital functioning, and higher levels of non-
communication and dissatisfaction with their sexual relationship; after unsuccessful treatment,
anxiety and depression increased and more than one fifth of women showed subclinical forms of
anxiety and/or depression six months after the last treatment cycle. Schmidt, supra note 164, at 379.
Studies differ on whether the duration of infertility or infertility treatment more accurately predicts
depression. Id.; Vivian Kraaij, Nadia Garnefski, & Anne Vlietstra, Cognitive Coping and Depressive
Symptoms in Definitive Infertility: A Prospective Study, 29 J. OF PSYCHOSOMATIC OBSTETRICS &
GYNECOLOGY 9-16 (2008). Depression scores may not decline significantly until after year six.

Domar, Broome, Zuttermeister, Seibel & Friedman, supra note 174, at 1161. Thus, many researchers
have concluded that “[d]epression is apparently a very common and significant problem in the
infertile population.” Id. at 1158-1163.

178 Domar & Cousineau, supra note 156, at 299. A 1998 study found that 54 percent of patients
exhibited mild depressive symptoms before their cycles, and 19 percent experienced moderate to
severe levels. K. Dmytrenaea, L. Bonte, M. Gheldof, et al, Coping Style and Depression Level

179 Bahman Baluch, Ian Craft & Talha Al-shawaf, What is Stressful About In-Vitro Fertilization?, 71
PSYCHOL. REP. 1188 (1992) (“We believe that . . . the psychological aspects of infertility are so great .
. . that worries about outcome overshadow concerns about the procedural aspects of the treatment”).

180 One study of 86 couples who experienced failed IVF treatment found that 66 percent of women
and 40 percent of men reported symptoms of depression afterwards, and one-third still exhibited
depressive symptoms 18 months later. D. Baram, E. Toutelot, E. Muechler & K. Huang,
Psychological Adjustment Following Unsuccessful In Vitro Fertilization, 8 J. PSYCHOSOMATIC

181 One study showed that emotional strain was moderately elevated during the first year of infertility,
that it assumed more typical levels during year 2, and that it increased during years 3 and beyond;
marital adjustment and sexual satisfaction also deteriorated after year 3. See generally Barbara J.

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appear to pathologize emotional distress too early in the treatment process and overemphasize the psychological impact of desperation or obsession to conceive.

B. Infertile Women’s Capacity for Choice

If women may effectively consent to abortion under social, physical, and temporal pressures, then surely they have the ability to give informed consent to ART. When an infertile woman looks in the mirror, she likely sees someone with many other qualities besides infertility. But even if she regards herself as desperate, she still would insist that she can make informed decisions. As Sandelowski remarks based on her interviews with infertile couples,

My respondent infertile couples do not construct the "alternatives" as the "pain, humiliation, and danger of in vitro fertilization" versus the "lowered self-esteem, devaluation, and loneliness of infertility." For them, the critical sets of options are trying to have a baby versus trying to get one; becoming a parent versus remaining without children; and, most importantly, having regrets for not pursuing a particular option versus having no regrets, even though they might remain child-free. They see and carefully consider the opportunity and danger attendant to both medical and adoptive routes to parenthood.182

To these ends, liberal feminists have sought to counter radical feminists’ anti-natalist perspectives; a strand of liberal feminist writing in the 1970s and 1980s pleaded for “caring, connected, authentic, antiviolent stereotypes of motherhood . . .”183 This strain of feminist thought strengthens arguments for “the return of agency to infertile women,”184 and liberal feminist scholars in the late 1980s and 1990s took up the cause.185 Liberal feminists credited ART with the “potential to articulate new ways of embodying reproduction . . . refus[ing] to read new reproductive technologies as simply signing and

Berg & John F. Wilson, Psychological Functioning Across Stages of Treatment for Infertility, 14 J. OF BEHAV. MED. 11 (1991). Similarly, a 2008 study found that a two to three year history of infertility and treatment duration added to the prediction of psychological distress, and that two years after the initial interview the mean depression score was still above average although fewer depressive symptoms were reported. Vivian Kraaij, Nadia Garnefski, & Anne Vlietstra, Cognitive Coping and Depressive Symptoms in Definitive Infertility: A Prospective Study, 29 J. OF PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 9-16 (2008). Yet another study found that the third year of trying to conceive was associated with the highest depression scores; the researchers hypothesized that “[i]t is possible that the third year is the most discouraging for patients; they are optimistic during the first 1 or 2 years, then begin to feel helpless during the second to third year, and finally start to resolve their feelings or move on to other alternatives. . . .” Domar, Broome, Zuttermeister, Seibel & Friedman, supra note 174, at 1161.

182 Sandelowski, supra note 53, at 39.
184 Id.
sealing preexisting oppressive social orders.” They rejected the image of infertile women as coerced creatures: “there are no more introspective and self-conscious decisionmakers than couples compelled to find the way to parenthood,” and asserted that ART could empower patients in numerous ways.

Contemporary liberal feminists are most likely to focus on the negotiation of maternal stereotypes, experiential accounts of patriarchy and infertility, the impact of increased fetal status and rights, and state concern about infertility. Recent liberal feminist scholarship actively counters radical feminist views, including developing more positive feminist images of infertile women, emphasizing that infertility is not an all-consuming condition, positing that stereotypes of desperation create caricatures of infertile women, and recognizing motherhood’s advantages and drawbacks. This scholarship has helped to demonstrate that infertile women can desire children for reasons that appear anything but irrational.

After interviewing infertile women about their treatment experiences, liberal feminist Gayle Letherby observes that respondents view desperation or obsession as only one aspect of their identities, and are people with feelings of despair rather than desperate people. Desperation may in fact be a conscious strategy; infertile women may even appear “desperate” if it will “improve the provision of medical and emotional support, or [if they] feel others are using this strategy.” Moreover, emotional distress may be a “reasonable, rather than an irrational, response” to infertility if

186 Id.
187 Id. at 43-44.
189 Id. at 66-7.
190 Gayle Letherby, Challenging Dominant Discourses: Identity and Change and the Experience of ‘Infertility’ and ‘Involuntary Childlessness,’ 11 J. OF GENDER STUD. 279 (2002) (stating that it is necessary to problematize the view that infertility becomes an individual’s master status).
191 Id. at 285. See Julia Mcquillan et al., The Importance of Motherhood Among Women in the Contemporary United States, 22 GENDER & SOC’Y 477-96 (2008) (analyzing the importance of motherhood among mothers and non-mothers, concluding that mothers can simultaneously value work and motherhood, and concluding that the “importance of work and the importance of motherhood are positively correlated, and for non-mothers, there is no association”—debunks notion that work-oriented women must be anti-child or that motherhood-oriented woman must be “anti-work”).
192 Miriam Ulrich & Ann Weatherall, Motherhood and Infertility: Viewing Motherhood Through the Lens of Infertility, 10 FEMINISM & PSYCHOL. 325 (2000). Ulrich and Weatherall focused on women’s reasons for wanting children (reasons cited were natural instinct, a natural relationship stage, social expectation, and the end result of decision-making process), the reality of mothering after successful infertility treatment, and how women spoke of infertility (descriptions included an awareness of its constructed nature, a rejection of infertility as being one’s whole identity, as illness and a medical problem, and as a failure). The authors concluded that a central theme of the accounts was “the important of increasing awareness and support” for infertile women, “the need to promote socially valued roles for women other than motherhood and the need to broaden what it means to “mother.”” Id. at 335.
193 Letherby, supra note 190, at 283.
194 Id. at 281. See infra pages 292-296.
one is barren yet feels that the “mandate for motherhood is compelling.”

The liberal feminist perspective also prompts us to be mindful of the dangers of overreliance on such false consciousness arguments, for to deny the authenticity of infertile women’s desire to conceive is to deny their free will and autonomy as well.196 We cannot condemn an individual’s desire to conceive simply because it might have been culturally conditioned. This absolutist stance ignores the fact that many everyday decisions, including life-changing determinations, are also culturally conditioned. Scholarship goes too far when it labels as “coerced” every woman whose reproductive choices align with patriarchal ideals. Yet, this characterization of the decision to conceive has been fairly influential, entering mainstream thought and informing the more conventional feminist ideal of motherhood on women’s terms and timing. Feminism, after all, is not about rejecting femininity, including maternity and motherhood. A feminist’s belief in and opposition to patriarchal hegemony does not automatically entail voluntary childlessness. Certain choices, such as motherhood, will inevitably align with patriarchal preferences—a fact that the women who make these choices, as well as feminists, have to accept. While it is important to recognize how certain behaviors support patriarchy, it is also crucial to realize that feminism is not only about appearing not to follow patriarchal dictates, but also about ensuring a respectful cultural space for women’s choices. Freedom of choice exists when a decision-maker is aware of her alternatives—the ability to remain childless or to attempt to conceive—and of likely emotional, psychological, social and financial consequences. Frustratingly, an infertile woman who is aware both of patriarchal conditioning and of her freedom to remain childless but still ardently desires a child can never articulate the authenticity of her choice if her consent is seen as inevitably coerced because of her sex. Overreliance on false consciousness theories, then, forces women to trade patriarchal subordination for feminist oppression—a fact recognized by more contemporary liberal feminists.197

C. Emotion’s Role in Decision-Making

We can also examine these contrasting constructions of women as reproductive decision-makers in a different way—as a case study of how we as social and cultural actors should understand and negotiate the roles of emotion in medical and reproductive decision-making. According to the U.S. Supreme Court’s abortion jurisprudence, emotion has long been recognized as a vital part of assessing various options and in evaluating the pregnant woman’s social and relational positions. After Gonzales v. Carhart,198 certain negative emotions, most obviously regret, are now judged an inherent part of the abortion decision. Foreclosing certain types of abortion options (such as “partial-birth” abortion), providing certain types of information to women experiencing crisis pregnancies, and enforcing mandatory waiting periods are all designed to “protect” women from suffering regret.199 Legal scholars writing from the feminist and law and emotion perspectives have observed

195 Ulrich & Weatherall, supra note 192, at 334-35.
196 Sandelowski, supra note 52, at 40 (“Feminist discourse that emphasizes the lack of authentic desire in women, or that allows women no free will beyond the will inculcated by patriarchal culture, itself permits women no volition, no agency at all.”).
197 See Rayna Rapp, Feminists and Pharmacists, WOMEN’S REV. OF BOOKS, July 1985, at 4;
Sandelowski, supra note 52, at 39.
199 See infra notes 121-137.
that women are capable and effective reproductive decision-makers when facing a crisis pregnancy, and that emotion is an inherent part of not only an informed decision to abort but also of social and cultural judgments concerning the propriety of a woman’s abortion decision.\textsuperscript{200}

In the infertility context, however, some legal scholars evaluate the emotion in decision-making very differently, arguing that infertile women’s desperation to conceive ostensibly leads them down dangerous paths to treatment decisions that jeopardize their physical, emotional, and financial well-being. I dispute that some women’s felt desire—indeed, desperate need—to abort a crisis pregnancy is so qualitatively different from the desire or even desperate need to conceive. Comparison of the scholarship surrounding abortion on the one hand, and IVF on the other, illustrates that legal scholars judge women’s emotional context as reproductive decision-makers quite differently across decision-making contexts.\textsuperscript{201} While infertility is an emotional issue, what is “emotional” is not inherently “irrational,” nor do women’s emotions—or emotional distress—rob them of the ability to make informed reproductive choices. In the abortion context, scholars have objected that acknowledging the abortion decision’s emotional nature need not compel the normative judgment that women are irrational or morally untrustworthy when confronted with such emotional decisions.\textsuperscript{202}

Incorporating emotion into theories of decision-making competency is a necessary step in recognizing infertile women as capable decision-makers. In Western countries, competence is essentially seen as cognitive.\textsuperscript{203} Competent individuals’ decisions are to be respected because they are the product of circumspection and intellectual judgments that certain options are desirable because their potential outcomes increase well-being.\textsuperscript{204} The choices of individuals with “disordered” minds, however, are not seen in the same light because their decisions are not the production of competent thought; it is easier for others to intervene in incompetent individuals’ decision-making processes because they cannot act in their own best interests.\textsuperscript{205} Significantly, competency is “decision-relative”; “... a person may be competent to make a decision at a particular time, under certain circumstances, but incompetent to make another decision, or even the same decision, under different conditions.”\textsuperscript{206} The size of any incompetent group must be sharply limited, because a declaration of incompetency is the most “profound infringement” of citizens’ rights.\textsuperscript{207}

By and large, adjudicating competence has largely fallen to common law courts,\textsuperscript{208} which have enunciated and applied tests for competency that include several key capacities: the abilities “to express a choice, to understand relevant information, to

\textsuperscript{200} Id.
\textsuperscript{201} Compare Waldman, supra note 16, and Shapo, supra note 33, with Siegel, supra note 102.
\textsuperscript{203} See, e.g., Charland, supra note 2, at 363.
\textsuperscript{204} Appelbaum, supra note 1, at 378.
\textsuperscript{205} Id.
\textsuperscript{206} ALLEN E. Buchanan & Dan W. Brock, Deciding for Others: The Ethics of Surrogate Decision Making 18 (1989).
\textsuperscript{207} Appelbaum, supra note 1, at 378.
\textsuperscript{208} Id.
appreciate the significance of that information for one’s own situation, and to reason with relevant information so as to engage in a logical process of weighing options.”\textsuperscript{209} Appreciation, in particular, “refers to a patient’s recognition that information given to them about their disorder and potential treatment is significant for and applicable to their own circumstances,”\textsuperscript{210} including not only understanding but applying abstract information on treatment risks and benefits to one’s own particular circumstances.\textsuperscript{211} This is typically seen as a primarily factual assessment related to intellectual capacity.\textsuperscript{212} A “patient’s belief must be substantially irrational, unrealistic, or a considerable distortion of reality” before she will be said to fail to appreciate medical information.\textsuperscript{213} It is on the grounds of appreciation that ART scholars fault infertility patients’ decision-making as the product of “denial, distortion, and delusions.”\textsuperscript{214}

Numerous researchers have complained that medical decision-making competence is not entirely cognitive in nature and should be expanded to include patients’ emotional capacities.\textsuperscript{215} According to LeDoux, cognition and emotion are inseparable in numerous neurophysiological structures and activities.\textsuperscript{216} Emotions actually inform the decision-making process because they prompt patients to think through conflicting “first-order desires” in line with closely-held values.\textsuperscript{217} Damasio has observed that individuals with frontal lobe damage score within normal ranges on cognitive testing but often prove incapable of social and relational tasks such as keeping a marriage intact or holding a job, which he attributes to an inability to experience or process emotion.\textsuperscript{218} Damasio’s research suggests that frontal lobe damage therefore cripples the human ability to consciously or unconsciously organize and utilize relevant past experiences and contemporary situational information so as to make competent decisions. Others assert that personal values guide patients’ decisions\textsuperscript{219} and observe that emotions are integral in evolving and discriminating among value systems. Therefore, as Charland queries, “if emotions are essential to everyday decision making and inseparably intertwined with other cognitive functions and capacities, then why are they not relevant to medical decision making in treatment and research contexts?”

\textsuperscript{209} Id. at 379; see generally Jessica W. Berg, Paul S. Appelbaum, & Thomas Grisso, “Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions,” 48 Rutgers L. Rev. 345 (1996).
\textsuperscript{211} Charland, supra note 2, at 363.
\textsuperscript{212} Betty Cox White, Competence to Consent 71 (1994); Charland, supra note 2, at 362.
\textsuperscript{214} Appelbaum, supra note 2, at 380.
\textsuperscript{217} White, supra note 212, at 131, 137.
\textsuperscript{218} See generally Damasio, supra note 215.
\textsuperscript{219} See generally Buchanan & Brock, supra note 205.
Processes of appreciation, a central component of decision-making competence, also rely upon emotion.220 “One interprets and evaluates the significance of events and situations in the environment (biological and social) in light of learned or pre-set goals and expectations,” including values and preferences, and thereby “comes to attach personal meaning to situations and events.”221 This is an active, not a passive, task, involving a “negotiation” between an individual and her environment, inherently involuntary, recursive and revisionary.222 Borrowing from the work of Richard Lazarus, Maroney explains how emotions influence cognitive appraisal:

In perhaps the most influential contemporary theoretical account of cognitive appraisal and emotion, Richard Lazarus posited that emotions are bound to core relational themes. Core relational themes are . . . captured as an “if-then” formulation: if a person appraises his or her relationship to the environment in a particular way then a specific emotion always follows. . . . Though “biological universals link the if with the then,” individual and cultural factors “affect the if” by influencing the appraisal. All persons who perceive their situation as satisfying one of the core relational themes will experience the corresponding emotion. But that perception is highly variable, for what circumstances are thought to constitute “a demeaning offense” or an “irrevocable loss” will depend on a person’s worldview, including internalized norms of her culture as well as her own experience, goals, motivations, and beliefs.223

Emotion, then, helps individuals to determine whether and how certain choices are personally meaningful, and thus aids in the process of appreciating treatment effects and outcomes. Treatment choices are not appreciated fully unless the choice is significant to an individual patient.224 Electing to proceed with treatment affirms a patient’s sense, after weighing the various options in light of anticipated goals, closely-held values, and awareness of chances of success, that a treatment option is viable and valuable as a possible means to desired ends, such as conceiving a child. Hence, Charland notes, such decisions “often involve very emotional and existential senses of “utility.””225 What emotions might be particularly salient in a decision to seek fertility treatment? Fear, hope, determination, perseverance, courage—all may be integral components of decision-making, and are likely to be far more prevalent than extremities of emotion such as desperation or obsession.

Of course, many critical and complex tasks lay ahead of us before we can determine if and in what ways emotional capacity should become part of a model of competency. We need a clear definition of emotional capacity, reason to believe that emotional capacity cannot only be defined but assessed, and a clear idea of what degree or

220 Charland, supra note 2, at 360.
221 Id. at 365-66 (discussing RICHARD S. LAZARUS AND BERNICE N. LAZARUS, PASSION AND REASON: MAKING SENSE OF OUR EMOTIONS 143-45 (1994)).
222 Id. at 366.
224 Charland supra note 2, at 368.
225 Id. at 370.
type of impairment is our focus.226 The idea of what constitutes a valid emotional test is a tremendous obstacle—how can one tell that a patient’s feelings are felt too strongly? Or whether they warp assessments of well-being, or whether they overwhelm the decision-making process? These are all high stakes questions; at immediate risk are patients’ moral and bodily integrity and autonomy, health, and constitutional rights. Nonetheless, we can see how the value of considering how emotions can enhance as well as detract from an understanding of medical—and reproductive—decision-making.

But emotion is not just important in helping patients to make medical decisions; it also plays a key role in how others evaluate those decisions—in short, in assessing their rationality. An individual is seen as competent if she can give rational reasons for a particular decision—a hard-to-define requirement referring to justifications that one would say are the product of “good sense” or “sound logic.” This rationality criterion is “process-centered,” and depends upon the characteristics of the decision maker as well as the social and cultural milieus in which the deciding individual—and the individual assessing the quality of the decision—are embedded.227 Freedman identifies two ways in which a decision maker’s reasons may fail the rationality test: deciding upon the basis of premises she knows to be false (such as refusing a breast biopsy in the belief it would affect future reproductive ability) and by producing reasons which although potentially true fail to support the conclusion drawn—in short, non sequitors (such as refusing surgery because it is Tuesday).228

A problem arises, however, when a decision to proceed with medical treatment makes sense from the patient’s perspective but does not appear quite so logical to others. Not only do we routinely make ostensibly irrational medical decisions, but we routinely evaluate judge others or for doing this very same thing. We think it is illogical when smokers not only acknowledge smoking’s health risks but overestimate them, and still make the ostensibly “irrational” decision to keep smoking.229 We find it unreasonable that many sexually active adults are familiar with HIV and AIDS prevention and the rules of “safe sex,” yet fail to take these very same steps to protect themselves.230

Let us briefly explicate legal scholars’ constructions of infertile women as “desperate” or “obsessed.” It might be that these scholars’ conceptions of infertile women are the products of what Maroney terms “emotional common sense,” defined as “what one thinks she simply knows about emotions, based on personal experience, socialization, and other forms of casual empiricism.”231 We rely on these common-sense ideas to help evaluate the “legitimacy and reliability of the information emotion imparts and the conclusions it compels.”232 Our emotional common sense discloses much about our “affiliations, beliefs, and values,” as well as what “normative ends” we view as the proper

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226 Appelbaum, supra note 2, at 383-84.
228 Id.
231 Maroney, supra note 223, at 851, 854.
232 Id. at 854-55.
outcome of a given situation; it “both colors interpretation of evidence and manifests in selective perspective-taking.”

As Maroney indicates, individuals with differing emotional common sense will also prioritize different outcomes, and so there is not merely one “correct” view. If used to gauge the lived experience of others, especially others who face decisions or diagnoses that we do not, then we might assume too much similarity between our emotional common sense and those of the individuals whose experience and decisions we are evaluating. Maroney terms this inaccurate conflation a “false consensus,” and warns that emotional common sense may be used to inject such “inaccurate suppositions” into the law, thereby enacting specific sets of values that may very well “ignore the equally legitimate worldviews of others.” In this situation, she cautions, “[e]motional common sense represents one way in which law may pass contentious judgments of value on by passing them off as uncontestable matters of fact.”

Emotional common sense is also marked by “extraordinary inconsistency,” in that “directly opposing folk beliefs may be held simultaneously and will be selectively invoked . . . .” Maroney faults the majority in Gonzales v. Carhart for relying upon “a common-sense judgment as to the emotional bond between mothers and children,” and “imput[ing] this bond to pregnant women and fetuses, . . . driv[ing] the resulting assessment of emotional reality for post-abortive women . . . .” Thus, Maroney asserts, the Supreme Court “adopt[ed] as relevant to the rights of others the amicus parties’ stories of grief, guilt, loss, and lowered self-esteem, it adopts the valuations and beliefs leading to those emotional outputs and forces a false consensus on them . . . . ignor[ing] other permissible meaning structures as to those phenomena.”

What exactly motivates scholars’ concerns over infertile patients’ decisions to proceed with fertility treatment? Is it because these women are vulnerable? Or because they might make unadvisable choices, making “bad” financial decisions or assuming unnecessary health risks and procedures that they will later regret? The exact reasons for concern have been left unspecified, but it is difficult to think of a more likely motivation than protecting them from regret. Even if the assumption is that infertile women are more vulnerable to manipulation than others (which has also been said of women facing crisis pregnancies), at bottom, concern over this vulnerability stems from fear that vulnerable individuals cannot fully appreciate the stakes of their decisions or may be maneuvered into making choices that are not in their best interests.

The logic implicit in current constructions of infertile women as desperate or obsessed seems to imply that, from the perspectives of scholars who have accepted or utilized such images, fertility treatment is an inherently regrettable options that one would have to be highly distressed—desperate—to accept. But ART scholars’ opinions reflect

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233 Id. at 858.
234 Id.
235 Id. at 864.
236 Id. at 864, 866.
237 Id. at 902.
238 Id. at 866.
239 Id. at 889.
240 Id. at 901.
their own worldviews and value judgments, and not necessarily those of all or even most infertile individuals, fertility patients, or indeed other law professors. These scholars weigh the high financial expenditures associated with treatment, its short and long-term side effects, and “low” chances of success, assign varying importance to each, and see a choice that is very likely to lead to patient regret. But infertility patients clearly weigh these factors very differently, most likely according higher priority to the possibility of achieving conception. It is no wonder that these two groups have such markedly different views of the rationality of pursuing fertility treatment.

If scholarly concern stems from an assessment that infertility patients will very likely regret their treatment decisions in the short or long term, and this assumption is incorporated into normative recommendations without actual empirical evidence as to who is likely to suffer regret or under what circumstances, then trouble looms on the horizon. This mirrors the difficulties that reproductive rights scholars contend are raised by Justice Kennedy’s insistence in Carhart that women seeking “partial-birth” abortions would experience regret. In short, in both contexts, justices and scholars “signal[] that [they] regard such regret as being a significant part of the natural order of things: women should feel these things, and therefore many of them will.”

And, in both contexts, regret is used to justify concerns about women’s reproductive decision-making capacity.

Behavioral law and economics research on regret aversion helps to illustrate why this approach is inappropriate. Regret aversion occurs when people make decisions calculated to reduce the possibility of post-decision regret. After making a decision, people compare the end result to what they feel the end result would have been if they had chosen differently; if they believe another choice would have led to a better outcome, then people will not only regret their decisions, but will take estimations of regret into account when making future decisions to try to minimize their sense of regret. Empirical research has documented regret aversion in consumer purchases, doctors’ and patients’ medical decision-making, adolescent sexual behavior, negotiation behavior, and gambling. Indeed, one study has concluded that IVF patients are motivated to undergo IVF to prevent feelings of regret. Behavioral law and economists have asserted that regret aversion is a form of hindsight bias that, like other forms of cognitive bias, prompts people to make irrational decisions. But if it is inappropriate for someone to make a decision based on regret aversion, as Behavior Law & Economics scholars claim, it also should be inappropriate for a third party to impose regret aversion upon a decision-maker to prevent her from making that choice. In other words, while we must accept that people face limitations as decision-makers by allowing for cognitive biases, we do not have to advocate

241 See Sandelowski, supra note 162, at 222 (stating that infertile couples prioritized trying to conceive and failing over not trying to conceive at all).
242 Maroney, supra note 223, at 894.
244 Id.
246 Guthrie, supra note 243, at 43; Michael A. McCann, “It’s Not About the Money: The Role of Preferences, Cognitive Biases, and Heuristics Among Professional Athletes,” 71 BROOK. L. REV. 1459, 1468, 1475 (2006) (defining cognitive biases as “subconscious mental processes that impair rational through-processes and ultimately lead to “irrational” choices.”)
for these cognitive biases by foreclosing the decision altogether. Such a step seems more in line with Aldous Huxley’s dystopian novel *Brave New World*, in which infertile women would be pacified by hallucinogenic Soma pills and sent on their way.²⁴⁷

Current constructions of infertile women’s “desperation” or “obsession” to conceive a child mischaracterizes their emotional stake in obtaining fertility treatment. It distorts their desire for a child into a vague, static, oversimplified abstraction, when in reality this desire, like other life goals, is a vibrant, revisionary, and subjective aspiration shaped by many factors. Ironically, however, these constructions are positive in one respect: they recognize that emotion affects medical and reproductive decision-making, and indicates that legal scholars have already incorporated an emotional element into models of decision-making competence, albeit in a problematic manner. Accepting that emotion is an integral part of decision-making that can assist women in making truly informed reproductive decisions allows us to see that infertile women have excellent—and rational—reasons for pursuing infertility treatment: a desire to conceive children (which may include having a child biologically related to one or both parents), a yearning for the experience of gestating and giving birth to a child, or other such goals. Reasons for pursuing treatment stem from a combination of emotional and rational factors—indeed, the very same combination of desires and rational considerations that prompt the vast majority of fertile couples to have children. And yet we rarely question whether such couples are rational in their decisions to start families. Infertile women pursuing treatment hope that technology will allow them to conceive, just as medical patients with different diagnoses elect a particular medical treatment in hope for a cure.

Cancer patients, for instance, often choose between several unappealing treatments with varying side effects and chances of success. Of course, the risks faced by cancer patients and infertility patients are by no means the same; cancer patients unquestionably face more dire needs than infertile patients who are otherwise healthy. They stand between treatment and the grave, not between potential conception and a childless life. Nonetheless, this comparison suggests that a treatment’s utility—and its rationality—may lie in the eye of its beholder. It is being forced into having to choose between treating a disorder or admitting that a cherished goal—living or conceiving—is unattainable that inspires so many to reach to pluck the fruit of possibility, regardless of whether it hangs high or low.

Research indicates that cancer patients are more likely than members of a non-cancer-patient control group to accept “intensive treatments for a potentially small benefit.”²⁴⁸ Slevin et al. reported that patients’ attitudes likely changed dramatically with cancer diagnosis, rendering them “likely to accept any treatment that offers them some possible benefit and hope, however slight,” because they “find it difficult to accept circumstances in which there are no therapeutic options” and “appeared to regard a minute chance of possible benefit as worthwhile, whatever the cost.”²⁴⁹ The study authors are reluctant to judge the cancer patients or even their decisions to be “irrational”: “It would be easy to conclude that this is an irrational decision resulting from the tremendous stress

²⁴⁷ In Huxley’s novel, Soma is a pleasure drug provides an escape from life’s hassles; the World State government utilizes Soma to maintain control over its citizens.
²⁴⁹ Id. at 1460.
imposed on these patients by their disease. This is by no means clear, however; it may be that the only people who can evaluate such life and death decisions are those faced with them. 250

If one can extend this study’s conclusions to infertility, they might not offer so much a lesson about desperation, obsession, or irrational decision making as about changes in values due to a perceived crisis and ensuing changes in treatment perspectives—the difference between being an outsider looking in to the experience of cancer or infertility, and an insider who must actually make decisions to deal with these diagnoses. Odds of success offer the potential for hope, however thin. If cancer patients prioritizing life choose a treatment option with terrible side effects and little chance of success, who are we to say this is irrational if it is the only way that they may achieve their goals?

IVF’s side effects are much less terrible than chemotherapy and it has fairly good chances of success for many if not most patients, and these odds are continuously improving with technological advances in reproductive medicine. Who are we to say that the decision to undergo IVF, even multiple times, is irrational? How can we fault infertile patients for decisions made out of unhappiness, discontent, and frustration with a medical diagnosis that forecloses their ability to fulfill an ardent desire and life goal that fertile others—not only desire but accomplish so effortlessly? How can we speak of all, most or even many infertile patients as “desperate” or “obsessed” instead of determined, optimistic, or courageous? There is nothing inherent in an infertile woman’s decision to seek medical treatment that renders that decision either rational or irrational—although, like other decisions made by individuals whose competence is not questioned in other medical contexts, it surely merits a strong presumption of rationality. Instead, construing infertile women’s decisions to undergo treatment entails making subjective cultural judgment as to what kinds of desires deserve protection, and thus necessarily of whom we should protect.

In reproductive and medical decision-making, it is important to acknowledge that people will at times make decisions that not others will perceive as “bad” and “irrational”; these decisions may even be ones that the decision-makers will come to regret. But this inevitability is inherent in the nature of human decision-making and individual autonomy. It does not mean that we should not continue to place a high value on individual autonomy (as our culture and Constitution do), particularly when deprivations are likely to reflect on gender stereotypes and will perpetuate these stereotypes and harm individuals affected by them. Thus, it is unnecessary (and impossible) to prove that women always make rational reproductive decisions; instead, we must ensure that they always have the autonomy to make those decisions.

Empirical research on exactly how and why infertile women make decisions in ART is an essential component of revising existing constructions. To date, no qualitative or quantitative research has examined infertility patients’ actual informed consent experiences. Research on informed consent for medical procedures other than ART paints a dismal picture, finding evidence for poor patient comprehension of informed consent

250 Id. There has been some attention focused, however, on how cancer patients’ emotional vulnerabilities. See, e.g., Natasha Singer, Cancer Center Ads Use Emotion More Than Fact, N.Y. TIMES, December 19, 2009, at A1; James Rickert, Letter to the Editor, Cancer Care: Deciding Where to Go, N.Y. TIMES, December 28, 2009 , at A26.
documents;\textsuperscript{251} patients who base medical decisions on fear, emotion, and religious beliefs instead of medically accurate information;\textsuperscript{252} and patients who prefer to defer to treating physicians’ recommendations rather than become extensively informed about clinical care details and risks\textsuperscript{253} or intimately included in medical decision-making. Some legal scholars assert that ART patients do not understand the technical medical details in informed consent documentation and that patients’ ability to understand and evaluate the forms is diminished by their desperation to conceive.\textsuperscript{254} Yet, it is highly likely that typical informed consent concerns—low comprehension, decision-making based on inadequate information—may not apply in the expected manner within ART because ART consumers are different in critical ways from other patients for whom different informed consent practices might be justified—they are not elderly or sick, and on average have higher incomes and more education. Accordingly, qualitative and quantitative research is urgently needed to fill a significant gap in the literature and to help shape emerging norms for ART decision-making.

### III. CONCEIVING CHANGE: WHY CONSTRUCTIONS OF INFERTILE WOMEN MUST BE REFORMED

Current constructions of infertile women in legal scholarship must be challenged and reformed lest they result in unnecessary and invasive alterations in treatment protocols, have stigmatizing effects, and reinforce paternalistic attitudes towards women and reproductive decision-making.

Legal scholars’ constructions of infertile women, their emotions, and their decision-making processes have important practical consequences. Legal scholars’ concern over the timing and pervasiveness of psychological distress and therefore the absence of decision-making capacity is wide of the mark. Because clinical research suggests that only a minority of infertile women may be subject to psychological distress stemming from infertility treatments, beginning not at the informed consent stage but after unsuccessful treatment, it is premature to focus on emotion’s effects upon decision-making before the first treatment cycle begins. It is unnecessary to require infertile women to do more than meet with a counselor to discuss the potential link between unsuccessful treatments and psychological distress, notify them of the availability of additional voluntary counseling, and provide other informed consent details.

To require more “protections” runs the risk of treating all infertile women as subject to psychological distress. Counselors can screen for mental health, identifying women most at risk for distress without undertaking more extensive mental health inquiries that will be intrusive and inefficient. Psychological evaluations are in danger of morphing into assessments of parental fitness. Psychological distress prompts labels antithetical to society’s conception of “fit” potential parents: individuals that are stable, rational, and able.

\textsuperscript{254} See, e.g., Waldman, \textit{supra} note 16, at 922–24; Krawiec, \textit{supra} note 30, at 7–8.
to utilize sound judgment.\footnote{255}{Charles P. Kindregan, Jr., Clarifying the Law of ART: The New American Bar Association Model Act Governing Assisted Reproductive Technology, 42 Fam. L.Q. 203, 216-217 (2008) (“It is difficult to articulate a justifiable reason to assess a prospective parent’s fitness to become a parent in advance of his or her reproductive efforts where medical procedures are necessary, but not in any other cases involving sexual, unassisted reproduction.”).}

In addition, the construction of infertile women as obsessed and desperate individuals has ideological consequences. Such portrayals have become stock narratives, images that acquire cultural popularity and resonance as a result of being continuously produced and reproduced, and eventually become stereotypes, as did the Victorian hysterical. References to desperate infertile women and couples have acquired great cultural significance.\footnote{256}{See, e.g., Andrea L. Bonnicksen, In Vitro Fertilization: Building Policy From Laboratories to Legislatures 47, 109 (1989) (discussing the popular stereotype of the “desperate patient”); S. Franklin, Deconstructing “Desperateness:” The Social Construction of Infertility in Popular Representations of New Reproductive Technologies, in THE NEW REPRODUCTIVE TECHNOLOGIES 220-29 (M. McNeil, I. Varcoe, & S. Yealey eds. 1990) (stating that one of the most common stereotypes of the IVF patient is of completely self-absorbed desperation). Bloggers have also lamented this pervasive popular culture stereotype. Cheryl Miller, Blogging Infertility, THE NEW ATLANTIS 19, 79-90 (Winter 2008), available at http://www.thenewatlantis.com/publications/blogging-infertility (“The number of times the word ‘desperate’ headlines an article on infertility is appalling.” Tertia [an infertility blogger] wryly agrees: “I hate the way the media portrays infertiles as sad, desperate women . . .”).}

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Legal scholars have contested similar stock narratives in the abortion context, criticizing the WPAA rationale as constraining women’s reproductive decision-making and reproductive rights, infringing on privacy and liberty interests, and interfering with self-conceptions and life goals; instead, they have proffered alternative constructions of pregnant women, abortion, and reproductive decision-making that emphasize bodily integrity, self-autonomy and accountability.\footnote{257}{For a discussion of stock narratives and their use in cognitive processing, see Jody Lyneé Madeira, A Constructed Peace: Narratives of Suture in the News Media, 19 Can. J. L. & Soc’y 93, 97-8 (2004).}

Current constructions of infertile women as desperate, unreasonable, or incapable of informed consent are influential stock narratives that others impose on infertile women.\footnote{258}{Letherby, supra note 190, at 286.}

These discursive formations are dangerous as they are absorbed into institutions and individuals’ lives, and resonate with other negative images of infertile women in popular culture.\footnote{259}{Marlo Campbell, The Baby Trap: Women Must Give Birth, Except When They Shouldn’t, WINNIPEG FREE PRESS (February 17, 2009).}

Contemporary women famous for conceiving multiples after fertility treatment are portrayed as “irresponsible, narcissistic, possibly mentally unstable and, above all else, selfish.”\footnote{260}{Marlo Campbell, The Baby Trap: Women Must Give Birth, Except When They Shouldn’t, WINNIPEG FREE PRESS (February 17, 2009).}
money and fame. Older women and young single women who conceive through IVF have also earned public criticism. “Octomom” Nadya Suleman has repeatedly declared desperate and emotionally or mentally unstable.

Unopposed by critical academic voices, these constructions will continue to dominate legal scholarship, influencing other scholars and lawmakers and becoming ever more stable and intransigent. Incorporated into judicial opinions and legal regulations, they could support legal regulations on ART. What began as a localized legal academic construction would therefore impact mainstream society, making the reaction to “Octomom” the norm rather than the exception. Sensations such as “Octomom” likely have more of an influence on popular culture—perhaps even legal culture—than does legal academia. But there is little reason for allowing such constructions to persist. Though ART is largely unregulated at present, it is unlikely to remain so forever. Part and parcel of developing an effective regulatory scheme will be identifying the fundamental values on which policies will be based. Developing accurate constructions of infertile women is essential to defining these guiding values.

The most immediate issue in the United States today is whether to place limits on the number of embryos to be implanted in a given IVF cycle. Scholars rightly question whether fertility clinics have an incentive to transfer more embryos to increase the odds of

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success, given the success/failure reporting requirements of federal law. Fertility clinics in turn have redirected the blame towards patients, claiming that parents would prefer twins to decrease costs and complete a family in a single pregnancy. Emphasis on the limits of maternal decision-making may open the door to more extensive regulation; if the legislations is part of a woman-blaming exercise rather than a realistic assessment of the commercial marketplace, the result may simply ultimately be unrealistic, ideologically driven, and may undermine better decision-making.

Finally, and most importantly, these constructions will have negative effects upon infertile women themselves. A widespread cultural belief that infertile women are irrational will hardly ease their social position, and may further lower self-perception and facilitate social misunderstanding. Analyzing prejudice and stigma's impact on members of stigmatized groups is not new; classics such as Gordon Allport’s The Nature of Prejudice and Erving Goffman’s Stigma: Notes on the Management of Spoiled Identity have inspired a profusion of research. In 1997, Steele and Aronson described how a widely known negative stereotype about a particular group that imperils its appearance of competence creates a “stereotype threat” when outsiders can judge a group member’s behavior in terms of that negative stereotype. Stereotype threats may apply to any stigmatized group and are situation specific. A threat is triggered when a group member realizes that a negative group stereotype can be applied and becomes anxious to disprove it, leading to distraction, self-consciousness, overcautiousness, and frustration. It is not necessary that a group member internalize or even believe a stereotype for stereotype threat to occur; the group member need only know that the stereotype exists and is applicable in a social situation.

Perpetuating the negative stereotype that infertile women’s decision-making abilities are imperiled by distress, desperation or obsession may create a stereotype threat that, even if it is disbelieved and not internalized, renders them defensive, self-conscious and anxious when fertility is socially salient. A diagnosis of infertility implicates not only physiological failure but mental dysfunction, even for fertile women undergoing treatment

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266 See, e.g., Ginny L. Ryan et al., The Desire of Infertile Patients for Multiple Births, FERTILITY & STERILITY 81, 500, 503 (2004) (reporting that “a sizeable minority prefers the situation that the medical community is trying hard to avoid” and that “the increase in the rate of multiple births may be in part patient driven”); Stephanie Saul, The Gift of Life, and Its Price, N.Y. TIMES (October 10, 2009), (stating “many women undergoing in-vitro prefer to have twins”); David Orentlicher, Multiple Embryo Transfers: Time For Policy, THE HASTINGS CENTER REP. (May-June 2010), (stating that “patients who want two children may prefer having twins with one IVF cycle than singletons in two cycles. Finally, some patients simply want twins.”); Miranda Hitti, Twins in Demand Through IVF, WebMD, available at http://www2.webmd.com/baby/features/twins-demand-through-ivf (“It's rare for IVF patients to bluntly request twins, and few ask for triplets or more, but many mention a desire for twins, IVF doctors tell WebMD.”).


268 Id.

269 Id.

with infertile partners. Increased self-consciousness, anxiety, and frustration can produce further physiological consequences detrimental to conception. Research documents a “mind-body” link in infertility; a very recent study found that women who participated in stress management programs with relaxation training, cognitive-behavioral strategies and group support were up to 160 percent more likely to become pregnant than women who did not.271 This suggests that stereotype threat makes an already stressful experience even more taxing, lowering odds of conception; thus, the invidious stereotype of infertile women as incapable decision-makers can affect the distribution of life opportunities—the chances to conceive, birth, and raise children.

Stereotype threat also implicates another issue—researchers of stigmatizing conditions often do not belong to such groups and therefore assume theoretical perspectives “uninformed by the lived experience of the people they study.”272 The result is that researchers may unwittingly misunderstand and misrepresent the lived experiences of stigmatized group members and maintain unsubstantiated assumptions.273

In addition, most infertile women are unlikely to challenge inaccurate constructions, since doing so might expose them to social isolation. Similarly, women who abort often do not feel comfortable informing others of their abortion to avoid social stigma:274 “[w]omen who have had an abortion may have good reason to fear being stigmatized—socially devalued, ostracized, and denigrated by others if their abortion becomes known.”275 Concealing abortion may “prevent the loss of important social networks and preserve social support.”276

Everyone is vulnerable to the effects of dominant discourses; infertile women must either accept or contest negative social constructions of themselves, their needs, and their experiences. There is little doubt that these constructions exert profound influence; Letherby reports that her infertile respondents are

273 Id.
274 See, e.g., Jane Greenway, Abortion—Ending the Taboo, 18 BRITISH J. OF NURSING 714 (2009) discussing social taboos and social disapproval related to abortion); Brenda Major & Richard H. Gramzow, Abortion as Stigma: Cognitive and Emotional Implications of Concealment, 4 J. OF PERSONALITY & SOC. PSYCH. 735 (1999) (“Women who have an abortion often do keep it a secret from others . . . . most women (approximately 85%) tell their conception partner of their pregnancy, but typically only two-thirds tell a friend, and less than a quarter tell their parents. . . ”). Many pro-life campaigns designed to prompt women to tell their abortion stories emphasize an end to silence, such as the “Silent No More” effort. See http://www.silentnomoreawareness.org/.
275 Major & Gramzow, supra note 274, at 735.
276 Id. at 736.
influenced by dominant and authoritative discourses in terms of their ‘choices,’ and in terms of the explanations and meanings they give their social experiences and biological identities. They cannot ignore dominant and authoritative discourses, and indeed they use aspects of them, reject others, and play a part in framing them . . .

While perhaps less stigmatized than abortion, infertility treatments are still controversial, and admitting to infertility treatment is arguably stigmatizing and establishes one as “other.” Infertile women’s supposed emotionality may degrade the perceived quality and value of their critical voices, diluting their influence. Moreover, empirical research suggests that if infertile women challenge such portrayals, their access to ART may be jeopardized. Assessments of infertile women’s mental health are currently mandated, if at all, by industry guidelines and model acts. American Society of Reproductive Medicine guidelines recommend that fertility clinic personnel include a “consultant/mental health professional with expertise in reproductive issues,” and fertility clinics interpret these guidelines to “require a psychological evaluation of each participant in any third-party reproduction prior to performing the medical procedures.”

In addition, the American Bar Association Model Act Governing Assisted Reproductive Technology provides for “an initial mental health “consultation” with all ART patients, consisting of a face-to-face meeting with a “licensed mental-health professional for the purpose of educating the participants about the effects and potential consequences of their participation in any ART procedure,” and about voluntary counseling. Further assessment requirements may increase costs for fertility treatments, rendering treatments too expensive and may waste precious time. It is also doubtful whether practitioners can accurately assess patients’ mental and emotional health during counseling sessions. Infertility patients play roles they deem most appropriate, either exaggerating “desperation” to enhance access to treatment or not admitting to distress during counseling. Furthermore, studies conclude infertility patients “display

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277 Letherby, supra note 190, at 286.
278 Scholars have been arguing since the early 1980s that infertility is a stigmatizing status and a taboo social subject. See NAOMI PFEEFFER & A. WOOLLETT, THE EXPERIENCE OF INFERTILITY 82 (1983).
279 See Arthur L. Greil, A Secret Stigma: The Analogy Between Infertility and Chronic Illness and Disability, in ADVANCES IN MED. SOCIOLOGY, VOL. 2, at 17-38 (G. Albrecht and J. Levy ed., 1991); Letherby, supra note 190, at 285-86 (“Non-mothers or women who achieve motherhood in unconventional ways are defined in lay, medical and even some social science and feminist literature as ‘problematic,’ ‘unnatural,’ ‘abnormal.’ . . . it is possible to argue that the ‘infertile’ and/or ‘involuntarily childless’ woman, the non-mother and the woman who has achieved motherhood unconventionally, are ‘other’ to the womanly feminine ‘ideal’”).
281 Kindregan, supra note 255, at 216-217.
282 Model Act § 301(1).
283 Id. at §§ 301(2), 302. The Model Act also defines qualifications necessary for mental-health professionals, and states that the result of the consultation may not be used to arbitrarily deny patients the right to procreate.
284 Letherby, supra note 190, at 281.
285 Klein, supra note 54, at 162.
exaggerated stereotypical gender attributes at appropriate times during treatment, perhaps to signal their fitness to become heterosexual nuclear parents . . .” and that “[p]atients had to act out these roles emotionally, economically, and legally to have access to treatments . . .”286

Challenging negative characterizations could prompt clinic personnel to label a patient as “difficult” and “uncooperative,” and perhaps even to refuse to treat her—scarcely the result sought by infertile women attempting to appear an ideal parent. Clinicians can determine who is and is not an ART candidate, placing the infertility patient “in the position of scrutiny and classification by the physician.”287 After asking infertility physicians in Finnish public and private infertility clinics how they formed impressions of female patients, Malin concludes that “[d]octors tend to inscribe certain value attributes to their patients, and their judgments materialize in the form of patient selection and treatment manners.”288 Malin’s respondents stated that state of health, including mental state, is the most important factor in IVF patient selection.289 Self-confident, urban, upper class patients, “assertive consumers of medical treatment,” were seen as threats and disliked because they questioned physicians’ authority.290 Physicians also believe “one has to be optimistic and cooperative for technological treatment to be successful,” and question whether “hostile, negative or depressed women would ever conceive either naturally or with the help of IVF.”291 For better or worse, “reproductive medical practices and discourses are an exercise in moral and social control.”292 Just as informed consent and embryo disposition forms are non-negotiable, forcing patients who disagree with terms to seek other providers, infertile women who question or challenge psychological evaluation results could be “fired” from their clinics. The best solution is not prohibiting ART but empowering infertile women. Two important steps towards more informed constructions of infertile women include acknowledging the pivotal role that emotion can play in reproductive and medical decision-making, and empirically assessing how women make decisions in ART contexts, investigating in particular the role of emotion.

CONCLUSION: FROM WOMAN SCORNED TO WOMAN COMPETENT

While clinical research recognizes that infertility can be emotionally distressing, legal scholars have added additional and unnecessary normative overlays to craft demeaning constructions of infertile women as emotional to the point of irrationality. The disparagement of infertile women, rooted in a physiological inability to conceive, sets off a chain of collapsing capacities. Bodily failure activates emotional frailty, jeopardizing rational decision-making and imperiling informed consent. Overemphasizing infertile women’s desperation or obsession with having children293 diminishes the scholarly inquiry

286 Thompson, supra note 183, at 65.
288 Id. at 302.
289 Id. at 304.
290 Id. at 307.
291 Id. at 312.
292 Id. at 313.
into the infertility experience and portrays these women as creatures driven by blind instinct rather than autonomous persons with the will and capacity to pursue identified life goals, including medical treatment.\footnote{See Pfeffer, supra note 293, at 84 (stating that “Men and women have clear limits beyond which they will not venture.”).}

These constructions of infertile women have serious ideological and practical consequences. They perpetuate emotional paternalism, and fail to recognize, respect, and accord legal weight to the dignity, autonomy, and capacity of infertile women. They imply that infertile women are somehow lesser decision-makers, denying the very reproductive autonomy and inherent potential for self-determination long celebrated in reproductive-rights case law and scholarship. These images demean and trivialize not only the desire to conceive and beget a child but also the experience of raising the child—the same opportunity that jurists have long sought to protect in privacy, First Amendment, and fundamental rights jurisprudence. Furthermore, such images may be used to justify restrictions on decision-making in ART. Although a pregnant woman’s right to choose abortion is time-tested and an infertile woman’s right to elect treatment has not been established to the same extent, affirming a woman’s reproductive freedom cannot be context-specific. Reproductive decision-making is not just a veto on unwanted pregnancies; it also encompasses the choice to conceive as well as the choice not to give birth. In both cases, the determinations, deeply personal and political, involving emotions and bodily integrity, deserve the utmost respect. Challenging and rehabilitating the portrayal of infertile women in legal scholarship is a powerful first step towards creating the “political and cultural conditions in which such technologies can be employed by women to shape the experience of reproduction according to their own definitions.”\footnote{Michelle Stanworth, Reproductive Technologies and the Deconstruction of Motherhood, in REPRODUCTIVE TECHNOLOGIES: GENDER, MOTHERHOOD, AND MEDICINE 35 (Michelle Stanworth ed., 1987).}

Exposing the damaging institutional and individual consequences of perpetuating inaccurate infertile women stereotypes is the first step towards evolving more accurate and empowering characterizations. Scholars must be extremely cautious about how law—and legal arguments—construct legal actors, lest academic efforts intended for good instead be used to perpetuate invidious patriarchal stereotypes. Challenging constructions of infertile women accomplishes more than affirming reproductive decision-making, it challenges a legal \textit{ideology}, with significant ramifications in the broader context of women’s rights.

Law has already begun to build upon protectionist constructions of women as coerced or ineffective reproductive decision-makers. Understanding the ideological development of such constructions is crucial for comprehending how legal constructions of women impact their legal rights, roles, and responsibilities.\footnote{Id. at 5.} After all, “[c]ompelling ideas, once unleashed and so influential as to become almost invisible, may be like tides that can take us to unexpected places.”\footnote{Id. at 6.}

are underway in the abortion context, where these perceptions are enshrined in legal policy. The struggle must continue in scholarship addressing infertility.

In actuality, infertility is not a “master status”—that social factor which is an individual’s primary identifying characteristic. One’s life does not stop with a diagnosis of infertility—bills must be paid, jobs performed, social obligations upheld, and fertility treatments do not delimit the boundaries of an infertile woman’s daily activities or life’s purpose. Just because infertile women are determined to conceive does not mean that they are irrational and incapable of informed consent. Rather, the lengths to which many go in researching physicians and treatments and finding support among others like them indicates the opposite—that these women care so very deeply about not only conceiving, but about how best to conceive, that they prepare themselves as thoroughly as possible for reproductive decision-making. This dedication may not be something that others—members of the “fertile world”—can easily understand or appreciate. Nor do doctors usually welcome patients’ intense scrutiny into procedures and success rates.

Nonetheless, respect for reproductive decision-making—and respect for all women, whether fertile or infertile—demands that infertile women be seen as capable, autonomous decision-makers who are trying to assert control over their psychological and physical selves, and over their lives. Indeed, “far from being mad, bad and desperate, involuntarily infertile women can be construed as survivors. They are people who have had to confront loss, grief and feelings of failure. These women are agentic and rational subjects who usefully inform our thinking about motherhood and infertility.”

Where can we turn to find more accurate constructions? Empirical research on infertile women’s experiences likely holds the key to forming more accurate constructions; what little qualitative research exists suggests that infertile women contextualize desperation or obsession to conceive as sources of frustration in lives full of other activities. Infertile women must be seen as women making reproductive choices that they authentically desire, have carefully considered, and have freely chosen. Pending the arrival of compelling new views of infertile women as competent decision-makers, however, we must continually question portrayals of infertile women and the judgments that such discourse may produce. Infertile women must not be seen as passive victims, but as active, circumspect participants in their treatment. To offer a modern variation on Descartes, infertile women think clearly, therefore they are. But if they are not believed to think clearly, than they are not. And others will abrogate the right to think for them.

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298 Id. at 49.
299 Letherby, supra note 190, at 279 (stating that it is necessary to problematize the view that infertility becomes an individual’s master status).
300 Ulrich & Weatherall, supra note 192, at 335.