
Maryland Law Review

VOLUME 71

2012

NUMBER 2

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Articles

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

JODY LYNEÉ MADEIRA*

ABSTRACT

Legal scholarship portrays women as reproductive decision makers in conflicting ways. The distinctions between depictions of infertile women and women considering abortion are 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 stereotypes of pregnant women considering abortion, depicting them as confident and competent decision makers. This Article argues that legal scholars' use of a "desperate woman" stereotype denies women's ability to critically assess the health risks and life benefits of fertility treatments, particularly when similar stereotypes have been met with scorn in the abortion context. These constructions perpetuate emo-

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* Associate Professor of Law, Indiana University School of Law, Bloomington, Indiana. J.D., University of Pennsylvania, 2003; Ph.D., Annenberg School for Communication, University of Pennsylvania, 2007. The author would like to thank Susan Ayres, Naomi Cahn, June Carbone, Glenn Cohen, Melissa Jacoby, Jaimie King, Leandra Lederman, Ken Levy, Terry Maroney, Donna Nagy, Aviva Orenstein, Tim Waters, Susan Williams, and Deborah Widiss for their invaluable comments on earlier drafts of this project, and Megan Mullett for her excellent research assistance.

tional paternalism; undermine the dignity, autonomy, and capacity of infertile women; and justify restrictions on decision making in the Assisted Reproductive Technology 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. To these ends, this Article examines the contributions that emotion can make to autonomous decision making, and the need for a more relational model of autonomy that acknowledges the socially embedded nature of treatment decisions. Because current constructions of “desperate” infertile women ignore available clinical research and have serious ideological and practical consequences, it is crucial to unmask and reframe them to prevent them from being incorporated into jurisprudence or legislation.

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I. INTRODUCTION

On January 26, 2009, Nadya Suleman, an unemployed single mother of six who was receiving public assistance,¹ gave birth to octuplets conceived through in vitro fertilization (“IVF”) using donated sperm.² Suleman’s story engendered profound controversy. She was criticized for consenting to transfer twelve embryos,³ and her reproductive endocrinologist, Dr. Michael Kamrava, eventually lost his California medical license after the state medical board ruled he had been grossly negligent “for an excessive number of embryo transfers” despite the fact that Kamrava believed the transfer was driven by Suleman’s wishes.⁴

Shortly after the Suleman story broke, fertility clinics across the United States were intensely scrutinized,⁵ 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” declared a living embryo to be 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.⁶ The Georgia Senate eventually passed an amended form of the bill stating that IVF embryos can only be created to initiate pregnancy.⁷ Missouri legislators considered a similar measure providing that physicians

1. Kimi Yoshino & Jessica Garrison, *Octuplets' Care Could End Up Costing Taxpayers Millions*, L.A. TIMES, Feb. 11, 2009, at B1.

2. *Donor Wants DNA Test for Octuplets*, CHI. TRIB., Feb. 24, 2009, at 13.

3. See, e.g., *Suleman Says She Was Drugged When She Consented to 12 Embryos*, CNN (July 29, 2011, 7:23 AM), <http://www.cnn.com/2011/SHOWBIZ/07/28/california.octomom> (last visited Feb. 21, 2012) [hereinafter *Suleman Says*] (noting that Suleman claims she has received death threats and is hated in her hometown). In IVF, a certain number of fertilized embryos (typically ranging from one to four) are transferred back into the intended mother’s uterus. PRESIDENT’S COUNCIL ON BIOETHICS, REPRODUCTION & RESPONSIBILITY: THE REGULATION OF NEW BIOTECHNOLOGIES 31 (2004). Much of the controversy stemmed from rumors that Suleman elected to transfer six embryos (two of which split into identical twins). Stephanie Saul, *Birth of Octuplets Puts Focus on Fertility Industry and Risks*, N.Y. TIMES, Feb. 12, 2009, at A1.

4. *Suleman Says*, *supra* note 3.

5. See Saul, *supra* note 3.

6. S.B. 169, 150th Gen. Assemb., Reg. Sess. (Ga. 2009). The act stated that “[i]n the interest of reducing the risk of complications for both the mother and the transferred in vitro human embryos, including the risk of 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.*

7. *Id.*

could transfer only as many embryos as recommended by the American Society for Reproductive Medicine.⁸

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 when it is medically necessary for a woman to have more than two or three embryos transferred.

The controversy surrounding how and why Suleman conceived her octuplets and the legislation this strange incident inspired illustrates how women's reproductive potential induces trepidation and disquiet in contemporary society and exemplifies how women's sexuality has become decoupled from reproduction, intensifying questions of ethics and morality.⁹ This incident also implicates historical Western social and scientific conceptions of women as excessively emotional beings with questionable decision-making ability.¹⁰ 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.¹¹ Such constraints are imposed even today, when the traditional individualistic and cognitive conception of informed consent—that patients are rational, autonomous beings ca-

8. See H.B. 810, 95th Gen. Assemb., 1st Sess. (Mo. 2009).

9. Fertility treatments such as IVF are often perceived as "messaging with nature" or attempting to "alter God's will." See James Chapman, *The Fatherless Baby*, DAILY MAIL (London), July 11, 2001, available at 2001 WLNR 2648874 (reporting that some experts think new developments in somatic cell transfers are "messaging with nature"); Carl H. Coleman, *Assisted Reproductive Technologies and the Constitution*, 30 FORDHAM URB. L.J. 57, 58–59 (2003) (noting that procreation through assisted reproductive technologies ("ART") poses significant problems from a religious perspective); Diane Eicher, *High-Tech Moms*, DENVER POST, May 14, 1995, at 10 (stating that some religious groups object to assisted reproduction as going "against God's will"); Andy Lines, *Triplets Who Are Aged 9, 6, and 2*, MIRROR (London), Dec. 29, 1999, available at 1999 WLNR 4936875 (reporting the criticism a married couple endured from friends who described their "decision to have test-tube babies as 'messaging with nature'"); Keith Suter, *Blessings Born by the Way of Science*, DAILY TELEGRAPH (Sydney), Jan. 16, 2006, at 22, available at 2006 WLNR 823947 (describing the Catholic Church's view that scientists should "not try to play God" by performing procedures using ART); Sonia M. Suter, *The "Repugnance" Lens of Gonzales v. Carhart and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies*, 76 GEO. WASH. L. REV. 1514, 1523 (2008) (noting that some have criticized IVF "for altering the natural process of reproduction and separating sex from procreation").

10. See *infra* text accompanying notes 173–174.

11. See *infra* text accompanying notes 49–53.

pable of reaching appropriate decisions about their own medical treatment¹²—is under assault, and when there is a growing awareness of emotion's role in decision making.¹³

Moreover, women making reproductive decisions in one context, such as infertility, may face stereotypes that have been challenged or rebutted in another context, such as abortion. Infertile women are scarcely the only population 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;

12. See, e.g., Paul S. Appelbaum, *Ought We to Require Emotional Capacity as Part of Decisional Competence?*, 8 KENNEDY INST. ETHICS J. 377, 378–79 (1998) (“Contemporary ideas of competence are tied inextricably to the ideal of self-determination in modern Western societies. Such societies are committed to respect for individual choice, both as a good in its own right and on the grounds that each person knows best what choices will maximize his or her own welfare.”).

13. See generally CARL E. SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* (1998); Louis C. Charland, *Appreciation and Emotion: Theoretical Reflections on the MacArthur Treatment Competence Study*, 8 KENNEDY INST. ETHICS J. 359, 359–61 (1998) (arguing that the concept of appreciation, “an essential ingredient of competence,” requires emotion). These efforts have resulted in a growing awareness of emotion's effects upon decisionmaking, and rumblings of discontent among advocates of cognitive theories of competence. To these ends, some scholars challenge the very notions of autonomy and rationality. See, e.g., SCHNEIDER, *supra*, at 47–108, (problematizing autonomy and stating that no truly rational decision is possible). A few suggest that many patients genuinely prefer to have doctors or family members make decisions for them. *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). 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. *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 J. AM. MED. ASS'N 2221, 2221 (1992) (discussing various models of physician-patient relationships, including a paternalistic model of the physician-patient relationship where the physician decides what is best).

one may seek or refuse medical treatment, but at the same time one 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.

Although they share many similarities, these two populations have received different treatment in legal scholarship; stereotypes of desperate women as irrational decision makers have been roundly rejected in the abortion context but not necessarily in the infertility context. There has been a robust, passionate defense of pregnant women’s ability to choose abortion; legal scholarship resounds with sharp criticism of the problematic “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.¹⁴ But there have been only isolated attempts to defend infertile women’s decision-making capacity,¹⁵ and some legal scholars have relied upon stereotypes similar to those rejected in the abortion context. These scholars claim that, for infertile women “desperate”¹⁶ to conceive, “[t]he power of wishful thinking obscures rational deliberation,” rendering them incapable of weighing the risks and benefits of treatment.¹⁷ Such assertions overemphasize the importance of the decision maker and her characteristics at the cost of a more thorough inquiry into her decision and its quality, and may underestimate or disregard emotion’s role in autonomous, competent decision making. Moreover, there is little evidence that emotion, even desperation, is as problematic as scholars suggest; clinical research belies any claim that distress leads to incapacity,¹⁸ and concludes that patients are most likely to experience severe emotional distress not at the pre-treatment stage of informed consent but after multiple unsuccessful treatment cycles, if at all.¹⁹

It is understandable that, to date, scholars have focused their energies and resources on combating more imminent and dangerous

14. See *infra* text accompanying notes 116–119.

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

16. Carson Strong, *Too Many Twins, Triplets, Quadruplets, and So On: A Call For New Priorities*, 31 J.L. MED. & ETHICS 272, 275 (2003).

17. Ellen A. Waldman, *Disputing over Embryos: Of Contracts and Consents*, 32 ARIZ. ST. L.J. 897, 923 (2000).

18. See *infra* notes 199–200 and accompanying text.

19. See *infra* text accompanying notes 202–205.

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 makers²⁰—must now be accomplished in the infertility context. The need to reject gendered, inaccurate, even offensive images of women as decision makers is reason enough to make such changes. But recent legislative efforts and the potential for future regulatory action render this issue even more urgent. We must take a hard look at the types of legislation that have been and are likely to 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.

To these ends, this Article will make two major contributions. First, it will establish that infertile women are autonomous and competent decision makers, despite the fact that they experience numerous emotions, perhaps including desperation, due to the emotionally challenging nature of infertility and infertility treatment.²¹ Second, this Article will argue in favor of acknowledging and incorporating the value of emotional elements in competent decision making.²² Our attention must be refocused from the decision maker and her emotions to the quality of the decision itself, as well as to the broader questions of emotion and its relationship to rationality, autonomy, and competence.²³ We need not reject the contention that infertile women experience desperation. Rather, we must reject the insinuation that desperation and other emotions warp infertile women's autonomy and decision making competency. Desperation—whatever its characteristics and however strongly it is felt—must be decoupled from irrationality.²⁴

Part II of this Article will explicate how and why contemporary characterizations of infertile women conflict so profoundly with legal constructions of women with unwanted pregnancies. It will first describe legal scholars' protectionist constructions of infertile women.²⁵ Thereafter, it will contrast these paternalistic characterizations with feminist legal scholars' empowering depictions of pregnant women considering abortion that have evolved in reaction to legislative and

20. See *infra* note 132 and accompanying text.

21. See *infra* Part III.B.

22. See *infra* Part III.C–D.

23. See *infra* Part IV.

24. See *infra* Part III.D.

25. See *infra* Part II.A.

judicial constraints on the abortion decision.²⁶ Finally, it will explore possible reasons for the strong tensions between these two constructions of women as reproductive decision makers.²⁷

In Part III, this Article will argue 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.²⁸ 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.²⁹ Finally, such portrayals misconstrue the productive role that emotion can play in reproductive and medical decision making for all women.³⁰

In Part IV, this Article will discuss the grave consequences of allowing current constructions of infertile women in legal scholarship to stand unchallenged. Drawing upon sociological theory, it will document how failing to combat protectionist portrayals of infertile women inevitably reinforces paternalistic attitudes toward women and reproductive decision making found in mainstream society.

II. WOMAN INEPT, WOMAN ADEPT: CONFLICTING LEGAL IMAGES OF WOMEN'S DECISION-MAKING AUTONOMY

A. *Infertile Women in Legal Scholarship*

While problematic constructions of pregnant women as inferior decision makers originated primarily in state and federal legislation and judicial decisions,³¹ constructions of infertile women as poor de-

26. *See infra* Part II.B.

27. *See infra* Part II.C.

28. *See infra* Part III.A.

29. *See infra* Part III.B.

30. *See infra* Part III.C.

31. *See infra* Part II.B. Only recently legislation has been proposed that would constrain infertile women's decision making (primarily by limiting how many embryos may be transferred in a cycle). *See, e.g.*, H.B. 810, 95th Gen. Assemb., 1st Sess. (Mo. 2009) (limiting the number of embryos that a physician may implant according to recommendations set forth by the American Society for Reproductive Medicine). Other forms of state legislation affirmatively encourage citizens to access fertility treatment, such as provisions that mandate that health insurance cover treatment procedures and medications, often including multiple cycles of intra-uterine insemination ("IUI") and IVF. *See, e.g.*, ARK. CODE ANN. § 23-85-137 (Supp. 2011), § 23-86-118 (2004) (requiring insurance companies to include IVF as a covered expense); CAL. HEALTH & SAFETY CODE § 1374.55 (West 2008) (mandating coverage for treatment of infertility, but excluding IVF from mandatory coverage); CONN. GEN. STAT. ANN. § 38a-536 and § 38a-509 (West 2007) (requiring insurance

cision makers are found predominantly 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,³² whether patients can adequately comprehend treatment risks and benefits,³³ and whether patients can cogently decide matters such as embryo disposition in the event of death or divorce prior to an IVF cycle.³⁴ 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.³⁵

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.³⁶ They recognize that IVF patients experience

companies to cover the medically necessary expenses related to infertility treatment, including, but not limited to "ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer"); 215 ILL. COMP. STAT. ANN. 5/356m (West 2008); MD. CODE ANN., INS. § 15-810 (LexisNexis 2006); MASS. GEN. LAWS ANN. ch. 175, § 47H, ch. 176A, § 8K, ch. 176B, § 4J, ch. 176G, § 4 (West Supp. 2011); 211 MASS. CODE RECS. 37.04-37.05 (2011); MONT. CODE ANN. § 33-31-102 (2009); N.J. STAT. ANN. § 17:48-6x, 17:48A-7w, 17:48E-35.22 (West 2008), 17B:27-46.1x (West 2006); N.Y. INS. LAW § 3216 (13), § 3221 (6), § 4303 (McKinney Supp. 2011); N.Y. PUB. HEALTH LAW § 2807-v (McKinney Supp. 2011); OHIO REV. CODE ANN. § 1751.01(A)(1)(h) (LexisNexis 2009); R.I. GEN. LAWS § 27-18-30, § 27-19-23, § 27-20-20, § 27-41-33 (2006); TEX. INS. CODE ANN. § 1366.001-1366.07 (West 2009); W. VA. CODE ANN. § 33-25A-2 (LexisNexis Supp. 2011).

32. See *infra* text accompanying notes 48–53.

33. See *infra* text accompanying notes 55–58.

34. See *infra* text accompanying notes 60–64.

35. Only one case addresses infertile individuals' vulnerability, and does so in dicta: In *United States v. Stover*, 93 F.3d 1379 (8th Cir. 1996), 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," and that the defendants "targeted those clients' emotional vulnerability by promising a 'quick fix.'" *Id.* at 1383–84. The government asked the appeals 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." *Id.* at 1384. 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.

36. Katherine T. Pratt, *Inconceivable? Deducting the Costs of Fertility Treatment*, 89 CORNELL L. REV. 1121, 1128 (2004) ("In numerous psychological studies, researchers have found that infertile women frequently suffer from severe depression.").

“extreme emotional distress” before and during infertility diagnoses,³⁷ and state that undergoing long-term infertility treatments can exhaust emotional, physical, and financial resources.³⁸ 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,³⁹ all symptoms contributing to depression.⁴⁰ 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.”⁴¹ And they make a number of problematic claims: that infertile women’s emotions render them particularly vulnerable to fraud and manipulation, and that these emotions interfere directly with their ability to make rational decisions.⁴²

Desperation and obsession become key focal points in such discussions, obscuring the distinctions between these emotions and clinical emotional distress. In vitro fertilization patients are deemed “emotionally weakened” by their failure to conceive a child.⁴³ For instance, Kansas Gooden remarks that “an infertile couple is often willing to go to any extent to have a child, including signing an informed

37. *Id.* at 1126–28. See also Carl H. Coleman, *Procreative Liberty and Contemporaneous Choice: An Inalienable Rights Approach to Frozen Embryo Disputes*, 84 MINN. L. REV. 55, 101 (1999) (noting that IVF patients experience intense emotions before beginning treatment and may have unrealistic expectations of success).

38. 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) (“Difficulty in conceiving a child is a deeply emotional experience.”); Judith F. Daar, *Regulating Reproductive Technologies: Panacea or Paper Tiger?*, 34 HOUS. L. REV. 609, 629 (1997) (acknowledging that infertility treatment often causes “tremendous emotional and psychological stress”); Pratt, *supra* note 36, at 1127–28 (“Long-term treatment of infertility exacts a heavy toll, both emotionally and financially. Infertility often has a devastating emotional effect, especially on women.”) (footnotes omitted); 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.”) (footnote omitted).

39. Byers, *supra* note 38, at 271; Waldman, *supra* note 17, at 923; see also Melissa Boatman, Comment, *Bringing up Baby: Maryland Must Adopt an Equitable Framework for Resolving Frozen Embryo Disputes After Divorce*, 37 U. BALT. L. REV. 285, 304 (2008) (noting that depression rates are high for infertile couples undergoing fertility treatment).

40. 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/decisionmaking, sexual dysfunction), and thoughts of death).

41. Byers, *supra* note 38, at 271.

42. See *infra* notes 43–47.

43. Jennifer L. Rosato, *The Children of ART (Assisted Reproductive Technology): Should the Law Protect Them from Harm?*, 2004 UTAH L. REV. 57, 71.

consent agreement.”⁴⁴ Similarly, Carson 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.”⁴⁵ And Kimberly Krawiec 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. . . . [A]ttempts to acquire a child often stop only when success is attained or access to funds runs out.”⁴⁶ The consensus is that these myriad vulnerabilities could potentially leave infertility patients open to emotional manipulation and exploitation.⁴⁷

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 and accepting involuntary childlessness. It is often unclear whether scholars perceive that emotions render infertility patients who initiate (and especially persist) with treatment tenacious or 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.”⁴⁸ Helene Shapo notes infertility’s fundamental emotional nature, opining that “[t]he usual premises of bargaining, efficiency, and rationality generally do

44. Kansas R. Gooden, *King Solomon’s Solution to the Disposition of Embryos: Recognizing a Property Interest and Using Equitable Division*, 30 U. LA VERNE L. REV. 66, 81 (2008).

45. Strong, *supra* note 16, at 275.

46. Kimberly D. Krawiec, *Price and Pretense in the Baby Market*, in *BABY MARKETS: MONEY AND THE NEW POLITICS OF CREATING FAMILIES* 41, 44 (Michele Bratcher Goodwin ed., 2010) (highlighting women’s desperation to emphasize that infertile women are incurring financial harm because of fee limits for donor eggs, which artificially constrain the egg donor market; she argues that lifting these restrictions might ensure greater availability of eggs, which may in turn lessen women’s desperation).

47. Byers, *supra* note 38, 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.”).

Nonlegal scholars also have addressed the potential for emotional manipulation. See Sharon Begley with Martha Brant, *The Baby Myth*, *NEWSWEEK*, Sept. 4, 1995 (describing various couples’ experiences “in the maw of the infertility machine” as “their own private Vietnams: . . . they can’t quit until they have a victory”); Elizabeth Bartholet, *In Vitro Fertilization: The Construction of Infertility and of Parenting*, in *ISSUES IN REPRODUCTIVE TECHNOLOGY: AN ANTHOLOGY* 253, 255 (Helen Bequaert Holmes ed., 1992) (describing a 1989 fertility clinic advertisement to demonstrate emotional appeals).

48. Sara Cotton et al., *Model Assisted Reproductive Technology Act*, 9 J. GENDER RACE & JUST. 55, 67 (2005).

not hold for people embarking on a program of IVF.”⁴⁹ Concerned about infertile couples’ vulnerability to manipulation, Michele 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.”⁵⁰ While infertile women look upon ART as “more than a rational choice . . . a blessing,”⁵¹ others—including 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.”⁵² Thus, the choice to begin or continue treatment is primarily framed as a somewhat irrational choice made by persons desperate to have a biological child.⁵³

Some scholars focus more intently on the legal implications of these “irrational” choices, especially on infertility patients’ diminished capacity to give informed consent because their emotions warp or defeat rational deliberation.⁵⁴ This perspective not only improperly conflates desperation with pathological distress, but it contradicts clinical research findings in at least two respects: (1) it fails to distinguish distress caused by unsuccessful treatment results from distress existing at the time of consent (when the former may be more severe), and (2) it conflates predictable and normal emotions, such as the desire to have a child, with more problematic and even pathological ones that could interfere with appropriate decision making.

49. Helene S. Shapo, *Frozen Pre-Embryos and the Right to Change One’s Mind*, 12 DUKE J. COMP. & INT’L L. 75, 103 (2002).

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

51. *Id.* at 18.

52. *Id.* at 54.

53. A Note in the *Harvard Law Review* asserts that “[c]onsumers 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.” Note, *In Vitro Fertilization: Insurance and Consumer Protection*, 109 HARV. L. REV. 2092, 2102 (1996). 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.” *Id.* at 2102–03. See also Note, *Assessing the Viability of a Substantive Due Process Right to In Vitro Fertilization*, 118 HARV. L. REV. 2792, 2811 (2005) (referring to infertile couples as “emotionally vulnerable” and susceptible to “exploit[ation] by opportunistic IVF providers”).

54. See Waldman, *supra* note 17, at 923–24 (arguing that the emotions experienced by women seeking infertility treatment may cause them to ignore anxiety-producing information, thus making their consent deficient).

Ellen Waldman describes infertility patients as victims of “selective perception,” who “selectively construct evidence that confirms their existing beliefs and desires.”⁵⁵ Hopeful and anxious, infertility patients “have difficulty absorbing medical information and rationally evaluating the risks and benefits of various treatment options.”⁵⁶ 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 that [ART] entails.”⁵⁷ 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.⁵⁸

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.⁵⁹ Some authors voice concern that patients make determinations “on the basis of feeling and instinct [rather] than rational deliberation,” and argue that inability to predict how one may feel in the future about the important individual right to decide how one’s reproductive capacity will be used undermines contractual capacity.⁶⁰ Emotions supposedly interfere with these decision making processes as well; scholars urge readers to consider the “fragile emotional and physical state of the patient at the time the agreement is entered into,” and warn that “parties rarely can fully appreciate the impact of their decisions when

55. *Id.* at 922.

56. *Id.* at 922–23.

57. *Id.* at 924.

58. *Id.* at 923–24.

59. *Id.* at 925.

60. Coleman, *supra* note 37, at 98–99 (arguing that the right to make decisions about embryo disposition should be made inalienable, meaning that one’s decision could be changed up until the moment of disposition, to “ensure[] that decisions will be based on a greater appreciation of the relevant facts”).

the agreements are signed, given the highly emotional circumstances of the agreement.”⁶¹

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 in the event they lose capacity or divorce before having a child.”⁶² Such problems are compounded, she cautions, by combining the embryo disposition form with other documents, which “will likely lead to psychological overload, and a glossing over the import of the information being conveyed.”⁶³ Similar concerns motivate Gooden to impose a framework that excludes emotions altogether, such as conceptualizing embryo disposition as property distribution.⁶⁴

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. Thus, it is not surprising that scholars assert that “the people who purchase fertility services don’t see themselves as participating in a commercial relationship.”⁶⁵ Here as elsewhere, infertile individuals’ desperation is seen to dictate choices.⁶⁶ As Krawiec 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.”⁶⁷

Significantly, legal scholars addressing the allegedly grievous consequences of infertile women’s desperation sincerely care about protecting women’s choices, and likely rely upon such stereotypes to demonstrate the need for changes in or restrictions upon ART services. Scholars such as Gooden wish to ensure that the choice to under-

61. Boatman, *supra* note 39, at 303, 305.

62. Waldman, *supra* note 17, at 925.

63. *Id.*

64. See Gooden, *supra* note 44, 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.”).

65. DEBORA L. SPAR, *THE BABY BUSINESS: HOW MONEY, SCIENCE, AND POLITICS DRIVE THE COMMERCE OF CONCEPTION* 49 (2006).

66. See *id.* at 48–49 (“The clients’ demand for the ‘product’ is exceedingly strong. They are willing to try anything . . . and they are essentially unwilling to give up.”).

67. Krawiec, *supra* note 46, at 45.

go fertility treatment is made carefully.⁶⁸ Krawiec herself has repeatedly noted that existing reproductive regulatory schemes propitiate gender and class stereotypes and biases and limit women's effective participation in reproductive markets.⁶⁹ She uses the stereotype of the desperate infertile woman to argue that infertile women are harmed by fee limits on donor eggs that artificially constrain the egg donor market, and contends that lifting these restrictions would ensure greater egg availability, lessening infertile women's desperation.⁷⁰ Other scholars are concerned that existing regulatory schemes and judicial decisions do not place effective limits on ART, a field with relatively little oversight.⁷¹ From this perspective, infertile women's emotions may render them vulnerable to potential exploitation⁷² 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. Indeed, these legal scholars are not the first to rely upon the desperation trope; others historically relied upon "desperate woman" stereotypes in the abortion context to illustrate the dangers of illegal abortions and the many societal, regulatory, and institutional roadblocks obstructing the path of choice.⁷³

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, or 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

68. Cf. Gooden, *supra* note 27, at 85–86 (arguing that a property interest theory of embryo disposition would eliminate the volatility associated with emotion, and thus result in more neutral and efficient decisions).

69. See, e.g., Kimberly D. Krawiec, *A Woman's Worth*, 88 N.C. L. REV. 1739, 1744, 1768 (2010).

70. See generally Krawiec, *supra* note 46.

71. See *supra* text accompanying notes 36–53.

72. Courts that face real-world decisions have largely supported women's capacity to make reproductive decisions. See, e.g., *Davis v. Davis*, 842 S.W.2d 588, 597 (Tenn. 1992) (stating that informed consent and disposition agreements should be binding 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.").

73. See *infra* note 145.

disproportionate emphasis. This logic is more woman-destructive than woman-protective, undermining decision-making autonomy and perpetuating invidious stereotypes. There are other, more relevant justifications for regulatory intervention, including limiting the health risks to mothers and fetuses that stem from multiple pregnancies created when more embryos than medically necessary are transferred.⁷⁴

Moreover, images of desperate pregnant women seeking to terminate unwanted pregnancies are easily distinguished from images of desperate infertile women seeking to conceive through IVF. In the abortion context, women's desperation to terminate an unwanted pregnancy is rooted in *external* societal constraints on the abortion decision; certain choices are not readily available or are altogether foreclosed. But in the infertility context, women's desperation is often portrayed as being *intrinsic* to their emotional state, the result of their profound desire to conceive and not the product of societal constraints on reproductive decision making.⁷⁵ The problem is not that infertility treatment is not readily available, or altogether foreclosed; it is that infertile women's emotions impair their ability to affirmatively choose to undergo procedures such as IVF. This intimates that the proper regulatory target is infertile women themselves, not other individuals or institutions.

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. Liber-

74. See Strong, *supra* note 16, at 273–74 (noting the significant risks to both mother and child involved in multifetal gestation).

75. Crucially, scholars, most notably Krawiec, may focus more on how infertile women's desperation results from external forces than on whether or not this desperation is inherent to their internal emotional states; however, scholars rarely elaborate upon the locus of this desperation, and most explicitly assert that it is an emotional consequence of women's infertile status.

al feminist⁷⁶ legal scholars have staunchly opposed these characterizations.⁷⁷ Depictions of women considering abortion in Supreme Court jurisprudence have morphed from *Roe v. Wade*'s circumspect rights-bearer who may obtain an abortion with only minimal physician consultation⁷⁸ to the more cautious and emotionally vulnerable individual portrayed in *Planned Parenthood v. Casey*⁷⁹ and *Gonzales v. Carhart*.⁸⁰

Roe defined the risks 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.⁸¹ *Roe* conceptualized the pregnant woman as subject to multiple burdens and harms, acknowledging the social, physical, and psychological hardships of childbearing and parenthood, and portrayed the difficult abortion decision as a medical one to be made by a woman *and* her physician.⁸² Subsequent cases addressed 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 birth control, adoption, and childbirth.⁸³ Here, the abortion decision is seen as one that must be protected from others' value judgments,⁸⁴ and that primarily lies with the woman.⁸⁵

Planned Parenthood v. Casey granted states more flexibility to persuade pregnant women against abortion, a "unique act . . . fraught with consequences for others."⁸⁶ The Court defined 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

76. 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 the purposes of this Article. Radical feminism explicates how patriarchal relationships and institutions oppress women and calls for profound social change.

77. See *infra* Part II.B.2.

78. 410 U.S. 113, 163 (1973).

79. 505 U.S. 833, 915–16 (1992).

80. 550 U.S. 124, 159 (2007).

81. *Roe*, 410 U.S. at 153.

82. *Id.*

83. *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists*, 476 U.S. 747, 764 (1986); *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 423 n.5, 445 (1983).

84. *Thornburgh*, 476 U.S. at 776–78 (Stevens, J., concurring).

85. *Id.* at 781.

86. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 852 (1992).

the matter.”⁸⁷ Emphasizing that the abortion decision should be “thoughtful,” “informed,” “deliberate,” and made after a “period of reflection,”⁸⁸ the plurality asserted that the state may “provide a reasonable framework”⁸⁹ to ensure that women accord this decision its due significance,⁹⁰ and that framework may include providing certain information highly relevant to a medical decision to abort.⁹¹ Thus, although *Casey* left a woman’s right to an abortion intact, it granted 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 *Gonzales v. Carhart*,⁹² in which the Court upheld the Partial-Birth Abortion Ban Act of 2003, a federal regulation prohibiting partial-birth abortion procedures without an exception to preserve the mother’s health.⁹³ The Court asserted that “[w]hether to have an abortion requires a difficult and painful moral decision,” one “fraught with emotional consequence.”⁹⁴ Justice Kennedy, writing for the Court, controversially remarked that “[w]hile we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.”⁹⁵ Therefore, he concluded:

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.⁹⁶

The rationale undergirding *Carhart* derives from post-abortion syndrome (“PAS”), a condition first proposed in the early 1980s by

87. *Id.* at 850.

88. *Id.* at 872, 885.

89. *Id.* at 873.

90. *Id.* at 872.

91. *Id.* at 872, 882.

92. 550 U.S. 124 (2007).

93. 18 U.S.C. § 1531 (2006).

94. *Carhart*, 550 U.S. at 159.

95. *Id.*

96. *Id.* at 159–60.

psychotherapist and counselor Vincent Rue,⁹⁷ who claimed that abortion was psychologically distressing and led to feelings of guilt⁹⁸ and other traumatic symptoms. Until the 1990s, the antiabortion movement relied upon a fetal-protective platform, and PAS was perceived by most to detract from the fetal rescue mission.⁹⁹ But, faced with Bill Clinton's election, the Supreme Court's preservation of *Roe* in *Planned Parenthood v. Casey*, and public ire over clinic violence and abortion doctor murders, abortion opponents began to view PAS as an ideal argument for reaching audiences concerned with women's rights and welfare.¹⁰⁰ It was in the early 1990s 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."¹⁰¹

Woman-protective antiabortion argument ("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.¹⁰² 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.¹⁰³ Notably, the stereotype of the pregnant woman who aborts incorporates not only stupidity and irrationality but also unnecessary risk-taking and careless decision making.¹⁰⁴ Representative Dick Armey stated that providing abortion services as part of a 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.'"¹⁰⁵

97. Ronald Turner, *Gonzales v. Carhart and the Court's "Women's Regret" Rationale*, 43 WAKE FOREST L. REV. 1, 23 (2008).

98. Reva B. Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1658 (2008); Turner, *supra* note 97, at 22.

99. Siegel, *supra* note 98, at 1660–62.

100. *Id.* at 1666–69.

101. *Id.* at 1669; *cf.* Turner, *supra* note 97, at 21.

102. Turner, *supra* note 97, at 21.

103. Rebecca E. Ivey, Note, *Destabilizing Discourses: Blocking and Exploiting a New Discourse at Work in Gonzales v. Carhart*, 94 VA. L. REV. 1451, 1453–54 (2008).

104. See David H. Gans, Note, *Stereotyping and Difference: Planned Parenthood v. Casey and the Future of Sex Discrimination Law*, 104 YALE L.J. 1875, 1902–03 (1995).

105. *Id.*

Most recently, the WPAA found fertile ground in South Dakota, where a legislative task force report on abortion greatly influenced the enactment of the Women's Health and Human Life Protection Act.¹⁰⁶ This act, passed in March 2006 as a blatant attempt to overturn *Roe*, was repealed on November 7, 2006, by a citizen referendum.¹⁰⁷ The act outlawed most forms of abortion, including for rape and incest, but preserved an exception to save the pregnant woman's life.¹⁰⁸ The task force report itself concluded 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.¹⁰⁹ The task force majority averred that women can *never* make an *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."¹¹⁰ Despite the defeat of the Women's Health and Human Life Protection Act, its history demonstrates the strength and appeal of WPAA's to contemporary audiences.¹¹¹

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."¹¹² He has asserted that "many women fundamentally do not want an abortion," but are pushed into it by social, situational,

106. H.B. 1215, 2006 Leg. Assemb., 81st Sess. § 1 (S.D. 2006) (repealed 2006).

107. *South Dakota Nixes Abortion Ban; Michigan Voters OK Anti-Affirmative Action Initiative*, FOXNEWS, Nov. 8, 2006, <http://www.foxnews.com/story/0,2933,228038,00.html>.

108. H.B. 1215, 2006 Leg. Assemb., 81st Sess. §§ 1, 2, 4 (S.D. 2006) (repealed 2006).

109. REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION 10, 13–14, 55 (2005).

110. Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, 1009–10.

111. Siegel notes 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, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 835 n.68 (2007) (citations omitted).

112. David C. Reardon, *Abortion Decisions and the Duty to Screen: Clinical, Ethical, and Legal Implications of Predictive Risk Factors of Post-Abortion Maladjustment*, 20 J. CONTEMP. HEALTH L. & POL'Y 33, 65 (2003).

and personal pressures, even against “maternal desire.”¹¹³ Reardon has opined that women considering abortion are unaware that “there is no medical evidence that abortion will actually produce the benefits they desire,”¹¹⁴ 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.”¹¹⁵

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 *Carhart*. Justice Ginsburg strenuously objected 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.”¹¹⁶ While she agreed that “for most women, abortion is a painfully difficult decision,” she disagreed with the majority's ruminations on “women's fragile emotional state” and accused it of “depriv[ing] women of the right to make an autonomous 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.”¹¹⁷ It would be more appropriate, she asserted, to “require doctors to inform women, accurately and adequately, of the different procedures and their attendant risks.”¹¹⁸ Justice Ginsburg then thoroughly repudiated 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.”¹¹⁹

Like Justice Ginsburg, feminist legal scholars object to WPAA assumptions that women are naturally predisposed toward 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

113. *Id.* at 66.

114. *Id.* at 61–62.

115. *Id.* at 55.

116. *Gonzales v. Carhart*, 550 U.S. 127, 183 (2007) (Ginsburg, J., dissenting).

117. *Id.* at 183–84 & n.7.

118. *Id.* at 184.

119. *Id.* at 184 n.9.

that a woman choosing abortion is not to blame for resulting emotional or physical harm.¹²⁰ These scholars fault these assumptions for pathologizing women's decisions to abort as "confused, misled, [] coerced," or abnormal.¹²¹ 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.¹²² Similarly, according to the WPAA, obtaining an abortion is inherently unnatural because it is both a non-maternal and non-procreative act.¹²³

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.¹²⁴ Feminist legal scholars argue that the needs of some emotionally vulnerable women should not dictate paternalistic reproductive policies for all.¹²⁵ 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.¹²⁶

Feminist legal scholars have also extensively criticized portrayals of the confused, uninformed, and weak-willed pregnant women inhabiting Supreme Court jurisprudence. Elizabeth Reilly argues that pregnant women have been portrayed as victims since *Roe*, at the mercy of pregnancy, enforced childbirth, and parenthood, and as patients who must consult with their physicians before acting.¹²⁷ She

120. Ivey, *supra* note 103, at 1491.

121. Siegel, *supra* note 98, at 1687.

122. Ivey, *supra* note 103, at 1499.

123. *Id.* at 1500.

124. Siegel, *supra* note 98, at 1688.

125. *See, e.g.*, Siegel, *supra* note 110, 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.").

126. 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.").

127. Elizabeth Reilly, *The "Jurisprudence of Doubt": How the Premises of the Supreme Court's Abortion Jurisprudence Undermine Procreative Liberty*, 14 *J.L. & POL.* 757, 771 (1998). *See also* Ivey, *supra* note 103, at 1481–83 (discussing how the Supreme Court has applied WPAA's logic in decisions from *Roe* to *Gonzales*).

observes that, in case law, pregnant women portrayed as victims are better able to obtain access to abortion, but pregnant women portrayed as powerful, autonomous agents encounter restricted access to abortion.¹²⁸ According to Reilly, the image of the pregnant woman 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.”¹²⁹ In a similar vein, Jack Balkin notes that 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.”¹³⁰ Rebecca Dresser, for one, has rejected this “psychological vulnerability” as unsupported.¹³¹ Scholars contend that women are actually astute predictors and mediators of their emotional states, anticipating and indeed overestimating regret, and proffer a more relational model of autonomy in contending that women make the abortion decision “within a web of interlocking, competing, and often irreconcilable responsibilities and commitments.”¹³²

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

128. Reilly, *supra* note 127, at 771–72.

129. *Id.* at 790–91.

130. Jack M. Balkin, *Original Meaning and Constitutional Redemption*, 24 CONST. COMMENT. 427, 527 (2007).

131. Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599, 1616–20 (2008) (discussing informed consent and how it has evolved from a “freedom of choice” doctrine to a doctrine that is intended to motivate women to choose what the legislature views as “morally appropriate” by seeking to highlight that women who receive abortions may suffer from psychological feelings of regret as a consequence of their choice if it is not fully informed).

132. Robin West, *Foreword: Taking Freedom Seriously*, 104 HARV. L. REV. 43, 82–83, 85 (1990). See also Samuel R. Bagenstos, *Disability, Life, Death, and Choice*, 29 HARV. J.L. & GENDER 425, 447 (2006) (“If one believes that the decisions of individual women typically are informed, deliberate, and not influenced by social pressures to have abortions, then the ‘informed consent’ restrictions upheld in *Casey* appear as nothing more than gratuitous interference with the right to choose abortion.”); Janet Benshoof, *The Chastity Act: Government Manipulation of Abortion Information and the First Amendment*, 101 HARV. L. REV. 1916, 1936 (1988) (arguing that marginalizing women’s autonomy to choose has negative implications for gender equality rights and serves to limit women within the legal system as autonomous individuals); Chris Guthrie, Carhart, *Constitutional Rights, and the Psychology of Regret*, 81 S. CAL. L. REV. 877, 882, 886, 902 (2008); Ivey, *supra* note 103, at 1453–54; Katherine C. Sheehan, *Toward a Jurisprudence of Doubt*, 7 UCLA WOMEN’S L.J. 201, 223 (1997) (contending that women are subject to undue burdens imposed by society and the courts that affect their ability to make free and individually motivated choices).

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, as shown through the abortion counseling and waiting period requirements.¹³³ 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.¹³⁴ Moreover, they assert, pregnant women who do not seek abortion are not exposed to informed consent materials and required to wait a statutorily specified time period before electing to continue their pregnancies.¹³⁵

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 women's bodies as means to social or moral ends.¹³⁶ Paternalism also results from viewing female reproductive capacity as "of concern to others" besides the woman herself.¹³⁷ The WPAA legitimates "anxiety" over female reproduction and female agency, enabling legal regulation.¹³⁸ Such paternalistic assumptions offend women's bodily integrity, damage women's identity and self-esteem,¹³⁹ and reduce women to their wombs.¹⁴⁰ Affirm-

133. Charlene Carres, *Legislative Efforts to Limit State Reproductive Privacy Rights*, 25 FLA. ST. U. L. REV. 273, 283 (1998); Gans, *supra* note 104, at 1903.

134. Gans, *supra* note 104, at 1903.

135. *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.").

136. DAVID A. J. RICHARDS, *TOLERATION AND THE CONSTITUTION* 268 (1986); *see also* Paula Abrams, *The Tradition of Reproduction*, 37 ARIZ. L. REV. 453, 489 (1995) (commenting on gender equality and liberty with respect to issues of reproductive law and arguing that courts have limited women's autonomy as decisionmakers by affirming states' imposition of paternalistic restrictions on their right to choose abortion); Bagenstos, *supra* note 132, at 456 (arguing that the "'informed consent' requirements in *Casey* reflect a gender-based paternalism towards women"); Heather A. Smith, Comment, *A New Prescription for Abortion*, 73 U. COLO. L. REV. 1069, 1079 (2002) (pointing to the "mandatory twenty-four hour waiting periods" imposed on women who are seeking abortion as a paternalistically imposed limit on women's right to choose).

137. Elizabeth A. Reilly, *The Rhetoric of Disrespect: Uncovering the Faulty Premises Infecting Reproductive Rights*, 5 AM. U. J. GENDER & L. 147, 183 (1996).

138. *Id.*

139. *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 decisionmaking, 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.").

ing a pregnant woman's decision-making capacity is to oppose paternalism,¹⁴¹ and to affirm feminine autonomy and control, and therefore feminine dignity.¹⁴²

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.¹⁴³ Effectively countering protectionist arguments requires first considering why scholars continue to make use of the desperate female reproductive decision maker stereotype for infertile women but reject it for pregnant women considering abortion.

The differences between the constructions of women seeking fertility treatment and women considering abortion do not merely indicate two conflicting portraits in awkward coexistence. While contemporary abortion scholarship portrays women as competent decision makers,¹⁴⁴ historically scholars writing on abortion emphasized women's vulnerability and desperation. Scholars used the dramatic portrait of the desperate pregnant woman to highlight the dangers of back-alley abortions, unsanitary conditions, and unscrupulous and unlicensed providers.¹⁴⁵ After abortion was legalized, scholars' abortion

140. *Id.* at 417.

141. *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.").

142. Siegel, *supra* note 111, at 818–19.

143. Compare Daar, *supra* note 36, at 629 (emphasizing the role of stress, both emotional and psychological, in the decision making of women seeking fertility treatment), and Waldman, *supra* note 17, at 923 (explaining that infertile women's ability to make rational decisions is undermined by the "power of wishful thinking"), with Guthrie, *supra* note 132, at 882 (suggesting that women contemplating abortion are able to harness the experience of regret into informed decision making).

144. See, e.g., Guthrie, *supra* note 132, at 893 (suggesting that most women who decide to obtain an abortion "will experience comparably high levels of well-being and comparably low levels of regret").

145. See Brief for Amici Curiae Women Who Have Had Abortions and Friends of Amici Curiae in Support of Appellees, *Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989) (No. 88-605) (including descriptions of women's experiences with illegal abortions, in which they characterize themselves as desperate and vulnerable); Richard Delgado & Judith Droz Keyes, *Parental Preferences and 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 (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'"); Andrea Dworkin, "Abortion," *Chapter 3, Right-Wing Women*, 1 LAW & INEQ. 95, 95 (1983) (describing "doctors who were asked for 'help' by desperate women"); Margie Ripper, *Abortion: The Shift in Stigmatisation*

arguments changed, focusing on what obstacles a state could legitimately place in women's paths.¹⁴⁶ Scholars' portrayals of the pregnant woman have accordingly evolved from a desperate woman into one who is a circumspect and competent reproductive decision maker.¹⁴⁷

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 and effect legal change,¹⁴⁸ 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.¹⁴⁹

Another apparent reason why liberal feminist scholars¹⁵⁰ have not yet addressed this issue is not willful ignorance but the altogether un-

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"); Ruth Roemer, Editorial, *The Right to Choose Abortion*, 64 AM. J. PUB. HEALTH 751, 751 (1974) (characterizing the pre-*Roe* period as a time when "dangerous, illegal abortion was the sole solution for desperate women faced with unwanted pregnancies"); Lynn D. Wardle, *Rethinking Roe v. Wade*, 1985 BYU L. REV. 231, 240 (referring to "invidious laws that were forcing desperate women to seek the radical remedy of abortion"). 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, 277 (2006) (stating that "[a] desperate minor may even feel compelled to seek an underground abortion").

146. See, e.g., Dresser, *supra* note 131, at 1616 (critiquing laws requiring women's informed consent before obtaining an abortion).

147. See *supra* notes 126–132 and accompanying text.

148. See, e.g., Roemer, *supra* note 145, at 821–22 (highlighting the need for change by emphasizing the difficulties that "desperate women" encounter when trying to obtain an abortion); Wardle, *supra* note 145, at 240 (explaining the effects of "invidious laws" on young and frantic women seeking an abortion).

149. See Coleman, *supra* note 37, 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"); Sara D. Petersen, *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); John A. Robertson, *In the Beginning: The Legal Status of Early Embryos*, 76 VA. L. REV. 437, 465 (1990) (explaining that "IVF programs and embryo banks may have such monopoly power that the conditions they offer give couples little real choice, making them the equivalent of adhesion contracts").

150. Early radical feminists, alarmed by the potential consequences of ART, have traditionally opposed ART services. See, e.g., Renate Klein, *From Test-Tube Women to Bodies Without Women*, 31 WOMEN'S STUD. INT'L F. 157, 157–58 (2008) (describing the development of organizations aimed at stopping the "dehumanising" reproductive technologies); Marga-

derstandable 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 the abortion decision, a matter long ago thrust into the heart of constitutional jurisprudence and privacy discourse, ART and stereotypes of infertile women have not been the basis of legal regulation. The abortion debate arguably came to a head in the 1980s, when states enacted legislation limiting women's abortion access and decision making.¹⁵¹ Only recently have threats to reproductive autonomy arisen in the infertility context.¹⁵²

A host of other reasons may underlie scholars' odd adherence to protectionism. Legal scholars may be uncomfortable making repro-

rete Sandelowski, *Fault Lines: Infertility and Imperiled Sisterhood*, 16 FEMINIST STUD. 33, 34 (1990) (arguing that fertility treatments are involved in the alienation of women from their bodies and their children); Christine St. Peter, *Feminist Discourse, Infertility, and Reproductive Technologies*, 1 NWSA J. 353, 355 (1989) (asserting that women will "buy the definition of infertility as disease, then buy the need for medically intrusive, expensive, and even dangerous 'cures'"). They asserted that infertile women sought to conceive to satisfy problematic psychological or psychiatric needs. See, e.g., PHYLLIS CHESLER, SACRED BOND: THE LEGACY OF BABY M 124 (1988) (arguing that a child has become "a 'life-style' commodity to be acquired"); Jalna Hanmer, *A Womb of One's Own*, in TEST TUBE WOMEN: WHAT FUTURE FOR MOTHERHOOD? 438, 445 (Rita Arditti, Renate Duelli Klein & 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."); 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 146, 153 (Patricia Spallone & Deborah Lynn Steinberg eds., 1987) (suggesting that the "craving to have a child" stems from a desire to have someone to control). These early radical feminists 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. See GENA COREA, THE MOTHER MACHINE: REPRODUCTIVE TECHNOLOGIES FROM ARTIFICIAL INSEMINATION TO ARTIFICIAL WOMBS 6 (1979) (stating that the "fact has not surfaced" that women suffer from IVF programs due to selective publicity that focuses only on successful treatments); Barbara Katz Rothman, *The Meanings of Choice in Reproductive Technology*, in TEST TUBE WOMEN, *supra*, at 23, 31-32 (explaining that the abundance of new infertility treatments do not enhance women's choices, but rather create a burden for infertile women who feel the need to try everything before finally giving up fertility treatments). This perspective painted infertile women's consent to ART as the inauthentic product of coercion, and thus of no real value. See COREA, *supra*, at 166. Although legal scholars locate infertile women's incapacity in emotion while radical feminists point to patriarchy, both arguments 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. See *id.*

151. See, e.g., The Pennsylvania Abortion Control Act of 1982, 18 PA. CONS. STAT. §§ 3203-3220 (1990), *upheld in part and invalidated in part* by Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 844 (1992).

152. See *supra* text accompanying notes 3-8.

duction a commodity.¹⁵³ Certainly there are people who make money in the ART business. Similarly, there may be less motivation to come to the aid of wealthy, educated women than to assist women 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.¹⁵⁴ It may be that infertile women are perceived to have viable alternatives to childbearing such as adoption.¹⁵⁵ 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 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.¹⁵⁶ Therefore, women seeking to conceive are ostensibly in need of more protection against the dominant culture.¹⁵⁷

III. COMMON MISCONCEPTIONS: WHY CONSTRUCTIONS OF INFERTILE WOMEN AND THEIR TREATMENT DECISIONS ARE INACCURATE

Legal scholars’ constructions of infertile women not only contradict other, more pervasive and empowering constructions of women

153. See, e.g., Mary Lyndon Shanley, *Collaboration and Commodification in Assisted Procreation: Reflections on an Open Market and Anonymous Donation in Human Sperm and Eggs*, 36 LAW & SOC’Y REV. 257, 272 (2002) (critiquing the buying and selling of genetic material).

154. 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. CHESLER, *supra* note 150, at 23; see also MARDY S. IRELAND, RECONCEIVING WOMEN: SEPARATING MOTHERHOOD FROM FEMALE IDENTITY 8 (1993) (describing the stereotype of “a socially isolated, career-driven woman consumed by a fatal jealousy and envy of motherhood and the nuclear family”).

155. 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 N.Y.S.2d 581, 593 (N.Y. App. Div. 1997) (stating that a woman’s preference for genetic parenthood should not override her former partner’s desire not to be a parent, unless she can show that no other means exist for her to become a parent), *aff’d*, 696 N.E.2d 174 (N.Y. 1998); *Davis v. Davis*, 842 S.W.2d 588, 604 (Tenn. 1992) (explaining that a woman’s desire to become a parent may outweigh her former partner’s wish not to become a parent if there are no other means for the woman to attain parenthood).

156. See St. Peter, *supra* note 150, at 355 (stating that women are “often conditioned to think of child-rearing as life’s primary focus”).

157. See *supra* note 150.

considering abortion, they also conflict with clinical psychological and psychiatric research addressing the link between infertility and emotional distress;¹⁵⁸ with normative arguments that ART expands women's reproductive choices and that women can freely choose to have children;¹⁵⁹ and with empirical research on the constructive roles that emotion can play in medical and reproductive decision making.¹⁶⁰ To these ends, this Part will describe why desperation must be decoupled from irrationality, explain why irrationality might not be the best framework for assessing the quality of infertile women's treatment decisions, detail emotion's valuable role in decision making, and demonstrate the need to recognize the socially embedded nature of infertile women as reproductive decision makers and of their treatment decisions.

A. *The Teachings of Clinical Research*

The coupling of irrationality and infertile women's alleged inclination towards emotional extremes originates in both centuries-old scientific and medical theories of hysteria and repronormativity.¹⁶¹ For hundreds of years, 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 organ¹⁶² that sometimes wandered off, causing physiological mayhem.¹⁶³ The prescribed remedy was to marry the suffering woman off so that the uterus could become

158. See *infra* text accompanying notes 177–180.

159. See Diane C. Parry, *Women's Experiences with Infertility: Exploring the Outcome of Empowerment*, 34 *WOMEN'S STUD.* 191, 195 (2005) (describing the position that reproductive technologies support women's "right to reproduce as they see fit").

160. See *supra* note 13.

161. This stereotype is not new; the idea that "women are naturally maternal, but not naturally rational" can be linked to Victorian ideology and historical images of hysterical women. See Siegel, *supra* note 110, at 1032–33 (comparing the portrait of a pregnant woman in emotional crisis considering abortion with the hysterical woman of the nineteenth century); Ivey, *supra* note 103, at 1496. Other scholars have documented the effects of feminism on law. See Jeannie Suk, *The Trajectory of Trauma: Bodies and Minds of Abortion Discourse*, 110 *COLUM. L. REV.* 1193, 1198 (2010) (examining how feminist critique has informed legal doctrine dealing with women's potentially harmful choices).

162. See ELISABETH BRONFEN, *THE KNOTTED SUBJECT: HYSTERIA AND ITS DISCONTENTS* 105 (1998) (describing how Hippocrates connected hysteria with "a restless, dissatisfied womb"); PHILLIP R. SLAVNEY, *PERSPECTIVES ON "HYSTERIA"* 14–15 (1990) (elaborating on how ancient scholars linked hysteria with sexual dysfunction); Gabrielle Murphy, *Hysteria's Story: History or Legend?*, 353 *THE LANCET* 1806, 1806 (1999) (explaining that the association between hysteria and the female reproductive system has long been recognized).

163. MARK S. MICALÉ, *APPROACHING HYSTERIA: DISEASE AND ITS INTERPRETATION* 19 (1995); PLATO, *TIMAEUS* (Benjamin Jowett trans., Project Gutenberg 2008) (360 B.C.E.).

grounded with a child.¹⁶⁴ By the seventeenth century, physicians no longer believed in the uterus with wanderlust, but theorized that uterine vapors interacted with other organs.¹⁶⁵ By the eighteenth century, the focus was on the brain itself, and hysteria became a disorder of the nervous system.¹⁶⁶ In the nineteenth century, Sigmund Freud proposed that hysteria was rooted in histories of trauma.¹⁶⁷ Hybrid neurouterine theories continued to emerge into the twentieth century.¹⁶⁸ Whatever its origins, the dimensions of hysteric behavior have remained the same: “highly negative character traits, including eccentricity, impulsiveness, emotionality, coquettishness, deceitfulness, and hypersexuality.”¹⁶⁹ Nervous hysterical disorders, allegedly caused by over-education and a luxurious lifestyle, were blamed for genteel infertility in wealthy classes.¹⁷⁰ As it gained recognition as a nervous disorder, hysteria became affiliated with a certain type of woman—an idle, delicate, and melancholic genteel white woman.¹⁷¹

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,”¹⁷² opposition to increased public roles for women was legitimized through medical research,¹⁷³ and hysteria became a warning about

164. DONALD CAPPS, *JESUS THE VILLAGE PSYCHIATRIST* 110 (2008); Murphy, *supra* note 162, at 1806.

165. BRONFEN, *supra* note 162, at 108.

166. *Id.* at 111.

167. Murphy, *supra* note 162, at 1806.

168. CAPPS, *supra* note 164, at 110.

169. *Id.*

170. See Laura Briggs, *The Race of Hysteria: “Overcivilization” and the “Savage” Woman in Late Nineteenth-Century Obstetrics and Gynecology*, 52 *AM. Q.* 246, 254–55 (2000).

171. BRONFEN, *supra* note 162, 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 170, at 247. Hysterical women were considered subconsciously self-absorbed and therefore frail. BRONFEN, *supra* note 162, at 114.

172. Briggs, *supra* note 170, at 248, 250.

173. As Laura Briggs asserted, “[l]ate nineteenth-century gynecological and obstetrical literature . . . naturalize[d] opposition to white women’s political struggles by insisting that contraceptive use, abortion, education, and participation in the professional workforce

the dangerous consequences for women of engaging in “unfeminine” behavior.¹⁷⁴

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.¹⁷⁵ 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.¹⁷⁶

Clinical research substantiates legal scholars' observations that infertile women are determined to conceive. Clinicians observe that infertility “becomes the focal point of daily discourse and tasks”¹⁷⁷ for infertile women, even becoming their sole focus,¹⁷⁸ and note that women are willing to try any viable treatment,¹⁷⁹ even those with a potential increased risk of ovarian cancer.¹⁸⁰ 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.¹⁸¹ Clinical statistics, however, show that the chances of successfully conceiving are much higher than legal scholars claim, making the choice to pursue ART more reasonable. In 2007, women 35 and younger enjoyed a 45.7 percent likelihood of becoming pregnant through IVF

could cause nervous illness.” *Id.* at 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.

174. *Id.* at 248. See BARBARA EHRENREICH & DEIRDRE ENGLISH, COMPLAINTS AND DISORDERS: THE SEXUAL POLITICS OF SICKNESS 40 (1973) (stating that “[t]he hysterical ‘type’ [was] . . . characterized as a ‘petty tyrant’ with a ‘taste for power’ over her husband, servants, and children . . .”); BARBARA EHRENREICH & DEIRDRE ENGLISH, FOR HER OWN GOOD: 150 YEARS OF THE EXPERTS’ ADVICE TO WOMEN (1978).

175. See *infra* note 196 and accompanying text.

176. See *infra* notes 183–184 and accompanying text.

177. Tara M. Cousineau & Alice D. Domar, *Psychological Impact of Infertility*, 21 BEST PRAC. & RES. CLINICAL OBSTETRICS & GYNECOLOGY 293, 295 (2007).

178. *Id.* at 296.

179. Judith Daniluk, *Helping Patients Cope with Infertility*, 40 CLINICAL OBSTETRICS & GYNECOLOGY 661, 665 (1997).

180. Brenda S. Houmard & David B. Seifer, *Infertility Treatment and Informed Consent: Current Practices of Reproductive Endocrinologists*, 93 OBSTETRICS & GYNECOLOGY 252, 256 (1999).

181. See Waldman, *supra* note 17, at 923–24 (explaining that women will undergo fertility treatment, even though “the chances for success are distinctly remote”).

without donor eggs, as did 37.2 percent of women 35 to 37; although pregnancy rates for older women were lower (28.1 percent for women 38 to 40, and 18.4 percent for women 41 to 42), 55.1 percent of IVF cycles using fresh donor eggs resulted in a live birth for all ages combined.¹⁸²

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 extensive research on infertility and treatment choices.¹⁸³ After conducting open-ended interviews with infertile couples undergoing IVF, Margarete Sandelowski and her co-authors note 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."¹⁸⁴

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.¹⁸⁵ Many research-

182. CTRS. FOR DISEASE CONTROL & PREVENTION, 2007 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES (2009), *available at* http://www.cdc.gov/art/ART2007/PDF/COMPLETE_2007_ART.pdf.

183. *See* Parry, *supra* note 159, at 202 (relating women's experiences of researching fertility treatments); *see also* Margarete Sandelowski, Betty G. Harris & Diane Holditch-Davis, *Mazing: Infertile Couples and the Quest for a Child*, 21 J. NURSING SCHOLARSHIP 220-26 (1989).

184. Sandelowski et al., *supra* note 183, at 223.

185. *See* SUSAN LEWIS COOPER & ELLEN SARASOHN GLAZER, CHOOSING ASSISTED REPRODUCTION: SOCIAL, EMOTIONAL & ETHICAL CONSIDERATIONS 17-18 (1998) (explaining the sense of loss and distress that accompanies infertility); BETH COOPER-HILBERT, INFERTILITY AND INVOLUNTARY CHILDLESSNESS: HELPING COUPLES COPE 32, 39-46 (1998) (describing a range of effects of infertility on a couple); JACOBS & O'DONOHUE, *supra* note 40, at 69 (discussing the "emotional roller coasting" of infertility); S.R. Leiblum, A. Aviv & R. Hamer, *Life After Infertility Treatment: A Long-Term Investigation of Marital and Sexual Function*, 13 HUM. REPROD. 3569, 3569 (1998) (stating that women can experience considerable disappointment when fertility treatments are unsuccessful); N.N. Mahajan et al., *Adjustment to Infertility: The Role of Intrapersonal and Interpersonal Resources/Vulnerabilities*, 24 HUM. REPROD. 906, 906 (2009) (stating that women often experience infertility with feelings of hopelessness and loss of control); Lone Schmidt, Comment, *Psychosocial Burden of*

ers have found that most infertility patients, particularly women, find infertility and its treatment to be “the most upsetting experience of their lives.”¹⁸⁶ An infertility diagnosis is often described as an intangible loss that triggers cyclical grieving like that from a loved one's death.¹⁸⁷ 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.¹⁸⁸ Infertility treatments also introduce new moral and ethical dilemmas if surrogates and donors are used.¹⁸⁹

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.¹⁹⁰ Women must carry the burden of an 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.¹⁹¹ Research also suggests that infertile women experience infertility as a chronic disease, experiencing levels of depression and anxiety indis-

Infertility and Assisted Reproduction, 367 THE LANCET 379, 379 (2006) (describing women in infertile relationships as having decreased self-esteem and lowered life satisfaction).

186. Cousineau & Domar, *supra* note 177, at 295.

187. See DEBRA BRIDWELL, THE ACHE FOR A CHILD 94–95 (1994); *The Psychological Impact of Infertility and Its Treatment*, 25 HARV. MENTAL HEALTH LETTER (Harv. Med. Sch.), May 2009, at 1–2 (“Individuals who learn they are infertile often experience the normal but nevertheless distressing emotions common to those who are grieving any significant loss . . .”).

188. See René M. Dunnington & Greer Glazer, *Maternal Identity and Early Mothering Behavior in Previously Infertile and Never Infertile Women*, 20 J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 309, 309 (1991) (explaining that infertile women experience a loss of maternal identity); Barbara Eck Menning, *The Psychosocial Impact of Infertility*, 17 NURSING CLINICS N. AM. 159 (1982) (explaining that women's self-images must be disconnected from child-bearing when they discover they are unable to have children); Robert D. Nachtigall et al., *The Effects of Gender-Specific Diagnosis on Men's and Women's Response to Infertility*, 57 FERTILITY & STERILITY 113, 113 (1992) (stating that infertility causes higher levels of stress in women than in men); Ellen Frances Olshansky, *Identity of Self as Infertile: An Example of Theory-Generating Research*, 9 ADVANCES IN NURSING SCI. 57–58 (1987) (describing how infertile women develop an identity focused on their infertility).

189. Cousineau & Domar, *supra* note 177, at 298.

190. *Id.* (stating that infertility can challenge the “core female identity” leading to diminished self-worth); see also COOPER & GLAZER, *supra* note 185, at 17–19 (finding that the female member of the infertile couple tends to exhibit higher levels of depression than the male); Judith C. Daniluk, *Infertility: Intrapersonal and Interpersonal Impact*, 49 FERTILITY & STERILITY 982, 988 (1988) (same); Schmidt, *supra* note 185, at 379 (same).

191. Cousineau & Domar, *supra* note 177, at 296 (stating that women are the “identified patient” who undergoes invasive procedures, monitoring, and scheduling disruption).

tinguishable from those of women with cancer, hypertension, myocardial infarction, or HIV.¹⁹² 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.¹⁹³

A number of important caveats bear upon the link between infertility and depression. Although there is disagreement as to whether infertility is correlated with clinically significant or pathological levels of distress, clinical researchers do agree that emotional distress is most likely to occur *subsequent to* a treatment cycle¹⁹⁴—after informed consent and embryo disposition forms are signed, and particularly after multiple failed treatment cycles.¹⁹⁵ Women may also “suppress or downplay their stress during treatment” to cope with the emotional strain of awaiting treatment outcomes,¹⁹⁶ perhaps providing further additional evidence that the onslaught of distress occurs later, not earlier, in the cycle, diminishing its effect on informed consent. Clinical researchers have also found that severely distressed women are more likely to *discontinue* treatment rather than persistently undergo cycle after cycle.¹⁹⁷ In addition, the infertility diagnosis itself impacts the likelihood that a woman will become depressed; women undergoing IVF because their male partners are infertile and who acknowl-

192. See A. D. Domar, P. C. Zuttermeister & R. Friedman, *The Psychological Impact of Infertility: A Comparison with Patients with Other Medical Conditions*, 14 J. PSYCHOSOMATIC OBSTETRICS & GYNAECOLOGY 45, 49 (1993) (suggesting that “the psychological distress which is associated with infertility can be as profound as with life-threatening illnesses such as cancer and heart disease”).

193. BRIDWELL, *supra* note 187, at 94–95, 129, 146.

194. See, e.g., Catherine H. Garner, Edward W. Arnold & Holly Gray, *The Psychological Impact of In-Vitro Fertilization*, 41 FERTILITY & STERILITY 13S (1984) (providing data that show couples exhibit increased behavioral responses, including anger, sadness, depression, and loss of self-worth, following an unsuccessful in vitro fertilization attempt).

195. A. D. Domar et al., *Psychological Improvement in Infertile Women After Behavioral Treatment: A Replication*, 58 FERTILITY & STERILITY 144, 146 (1992) (noting that “recent research has demonstrated that symptoms of depression, hostility, and anxiety increase as duration of infertility treatment increases.”).

196. Koen Demyttenaere et al., *Coping Style and Depression Level Influence Outcome in In Vitro Fertilization*, 69 FERTILITY & STERILITY 1026, 1027 (1998). See also Jacky Boivin & Janet E. Takefman, *Stress Level Across Stages of In Vitro Fertilization in Subsequently Pregnant and Non-pregnant Women*, 64 FERTILITY & STERILITY 802, 808 (1995) (finding that women reported lower levels of stress while awaiting the results of treatment, but recalled the waiting period as one of the most stressful stages after becoming aware of the results of treatment).

197. Demyttenaere et al., *supra* note 196, at 1026 (“Some studies have demonstrated that higher trait anxiety levels or higher depression levels . . . increase the likelihood that a woman will abandon further IVF attempts.”).

edge negative emotions are less likely to be depressed than women who are diagnosed as infertile.¹⁹⁸

Finally, clinical researchers emphasize clinical depression, not the frantic and endless pursuit of pregnancy that terms such as “desperation” and “obsession” imply. While studies substantiate a link between infertility and distress, they do not correlate distress to incapacity, or equate desperation to clinical depression. Research differs as to how strongly depression is tied to infertility, with some studies supporting a link¹⁹⁹ and others concluding that no correlation exists.²⁰⁰

198. *Id.* at 1033.

199. 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 two or three times more than fertile women. See, e.g., Ting-Hsiu Chen et al., *Prevalence of Depressive and Anxiety Disorders in an Assisted Reproductive Technique Clinic*, 19 HUMAN REPRODUCTION 2313, 2317 (2004) (finding infertile women who were preparing for a new course of ART had higher depressive symptoms than women in the general population); J. Cwikel et al., *Psychological Interactions with Infertility Among Women*, 117 EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY & REPRODUCTIVE BIOLOGY 126, 128 (2004) (collecting studies that support a connection between infertility and depression); Alice D. Domar et al., *The Prevalence and Predictability of Depression in Infertile Women*, 58 FERTILITY & STERILITY 1158, 1160–61 (1992) (finding that 37 percent of infertile women scored in the “depressed” range on the Beck Depression Inventory as compared to 18 percent of control subjects, with 8.4 percent of infertile women experiencing symptoms in the severe to extremely severe range); Domar et al., *supra* note 195, at 147 (concluding that behavioral treatment is associated with improvements in the psychological symptoms often experienced by infertile women); Jennifer Downey & Mary McKinney, *The Psychiatric Status of Females Presenting for Infertility Evaluation*, 62 AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY 196, 203 (1992) (finding that 11 percent of infertile women satisfied criteria for a major depressive episode, as compared with 3.6 percent of control subjects); A. Eugster & A.J.J.M. Vingerhoets, *Psychological Aspects of In Vitro Fertilization: A Review*, 48 SOC. SCI. & MED. 575, 580–81 (1999) (finding that anxiety and depression are among the most common reactions to treatment); Catherine H. Garner et al., *supra* note 194, at 13S (concluding that 64 percent of women undergoing IVF reported depressive symptoms as measured by a modified Beck Depression Inventory after an unsuccessful IVF cycle); John Wright et al., *Psychological Distress and Infertility: Men and Women Respond Differently*, 55 FERTILITY & STERILITY 100, 104 (1991) (finding that infertile women had higher levels of depressive symptoms than their partners). The stage and form of infertility diagnosis seem 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. Domar et al., *supra*, 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 245, 249–250 (1999) (finding that 56 percent of IVF patients and 58 percent of patients who took ovulation-induction medication 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).

200. Other sources conclude that anxiety, depression, and other mental health disorders are not greater among infertile women than in the general population. For example, a 2009 World Health Organization report states that “a number of cohort comparison stu-

dies . . . have found no significant difference in rates of psychiatric illness, other psychopathology or personality factors between presumed fertile groups and those seeking infertility treatment, or between infertile groups and population norms, or between groups with infertility of different origin and duration.” 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 (citations omitted); R.J. Edelman et al., *Psychogenic Infertility: Some Findings*, 12 J. PSYCHOSOMATIC OBSTETRICS & GYNAECOLOGY 163–68 (1991); A.P. Visser et al., *Psychosocial Aspects of In Vitro Fertilization*, 15 J. PSYCHOSOMATIC OBSTETRICS & 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. See 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); Jennifer Downey et al., *Mood Disorders, Psychiatric Symptoms, and Distress in Women Presenting for Infertility Evaluation*, 52 FERTILITY & STERILITY 425, 429 (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); Christine Dunkel-Schetter & Marci Lobel, *Psychological Reactions to Infertility*, in INFERTILITY: PERSPECTIVES FROM STRESS AND COPING RESEARCH 29, 50 (Annette L. Stanton & Christine Dunkel-Schetter eds., 1991) (finding that “[e]mpirical evidence from scientifically rigorous research on the psychological effects of infertility does not support contentions that specific reactions are common.”); M. T. Hearn et al., *Psychological Characteristics of In Vitro Fertilization Participants*, 156 AM. J. OBSTETRICS & GYNECOLOGY 269, 272 (1987) (finding that couples undergoing IVF reported good quality of life and that women undergoing IVF did not differ from the normal sample with respect to depression and anxiety); John D. Paulson et al., *An Investigation of the Relationship Between Emotional Maladjustment and Infertility*, 49 FERTILITY & STERILITY 258, 261 (1988) (finding that “infertile women do not manifest significantly greater levels of emotional maladjustment than do women in general.”); Annette L. Stanton & Sharon Danoff-Burg, *Selected Issues in Women’s Reproductive Health: Psychological Perspectives*, in THE PSYCHOLOGY OF WOMEN’S HEALTH: PROGRESS AND CHALLENGES IN RESEARCH AND APPLICATION 261, 275 (Annette L. Stanton & Sheryle J. Gallant eds., 1995) (finding that “the conceptualization of infertility as a uniform life crisis was not supported in the empirical literature”).

Failure to observe clinical anxiety or symptoms of depression, 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. See Janet Beaurepaire et al., *Psychosocial Adjustment to Infertility and Its Treatment: Male and Female Responses at Different Stages of IVF/ET Treatment*, 38 J. PSYCHOSOMATIC RES. 229, 238 (1994) (comparing male and female responses at varying stages of fertility treatment and concluding that “a major difficulty faced by both men and women regardless of stage of treatment was anxiety”); J. Bernstein et al., *Assessment of Psychological Dysfunction Associated with Infertility*, 14 J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 63–66 (1985); Victor J. Callan & John F. Hennessey, *The Psychological Adjustment of Women Experiencing Infertility*, 61 BRIT. J. MED. PSYCHOL. 137, 139 (1988) (finding that infertile women “perceived their lives as less interesting, more lonely and in general were less contented than mothers not experiencing fertility problems”); Daniluk, *supra* note 190, at 988 (comparing levels of depression in infertile couples at diagnosis and in later stages of treatment and finding that distress decreased as medical investigation continued); Kelly A. Morrow et al., *Predictors of Psychological Distress Among Infertility Clinic Patients*, 63 J. CONSULTING & CLINICAL PSYCHOL. 163, 166 (1995) (concluding that the incidence and severity of psychological distress in infertile patients warrants psychological evaluation and therapy); Nachtigall et al., *supra* note 188, at 116–18 (reporting

Specifically, studies show that an infertile individual's mental health correlates to both infertility and treatment experiences.²⁰¹ Many IVF patients experience depressive symptoms before an IVF cycle, particularly if they have experienced multiple unsuccessful rounds.²⁰² These symptoms, however, stem from patient apprehension over treatment outcome and not the procedures themselves.²⁰³ 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.²⁰⁴ The consensus is that emotional strain increases over the first two years of treatment, peaking around year three.²⁰⁵ Thus, legal

that women in infertile couples exhibited loss of self-esteem, feelings of stigma, role failure and perception of loss, regardless of whether a female infertility factor was present).

201. *The Psychological Impact of Infertility and Its Treatment*, *supra* note 187, at 1. For instance, one study concluded that six months after either completing three IVF cycles without *becoming pregnant*, women who were unable to conceive "had significantly higher levels of anxiety and depressive symptoms, poorer marital functioning, and higher levels of non-communication and dissatisfaction with their sexual relationship" compared with women who *became pregnant*; "after unsuccessful treatment, anxiety and depression increased More than a fifth of the women showed subclinical forms of anxiety and/or depression." Schmidt, *supra* note 185, at 379. Studies differ, however, on whether the duration of infertility or infertility treatment itself more accurately predicts depression. *See id.* (referring to infertility as a "chronic stressor" that couples must continually address); *cf.* Vivian Kraaij et al., *Cognitive Coping and Depressive Symptoms in Definitive Infertility: A Prospective Study*, 29 J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 9, 13–14 (2008) (finding that infertile patients reported fewer depressive symptoms two years after the initial interview). Depression scores may not decline significantly until after year six. Domar et al., *supra* note 194, at 1161. Thus, researchers have concluded that "[d]epression is apparently a very common and significant problem in the infertile population." *Id.*

202. Cousineau & Domar, *supra* note 177, at 299. A 1998 study found that 54.1 percent of patients exhibited mild depressive symptoms before their cycles, and 19.4 percent experienced moderate to severe levels. Demyttenaere et al., *supra* note 196, at 1028.

203. Bahman Baluch et al., *What Is Stressful About In-Vitro Fertilization?*, 71 PSYCHOL. REP. 1187, 1189 (1992) ("[W]e believe that . . . the psychological aspects of infertility are so great that worries about outcome overshadow concerns about the procedural aspects of treatment.") (citations omitted).

204. One study of eighty-six 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 eighteen months later. D. Baram, E. Tourtelot, E. Muechler & K. Huang, *Psychological Adjustment Following Unsuccessful In Vitro Fertilization*, 8 J. PSYCHOSOMATIC OBSTETRICS & GYNAECOLOGY 181 (1988).

205. One study showed that emotional strain was moderately elevated during the first year of infertility, that it assumed more typical levels during year two, and that it increased during years three and beyond; marital adjustment and sexual satisfaction also deteriorated after year three. Barbara J. Berg & John F. Wilson, *Psychological Functioning Across Stages of Treatment for Infertility*, 14 J. BEHAV. MED. 11, 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

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

B. Recognizing 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 Margarete 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.²⁰⁶

To these ends, liberal feminists in particular have sought to counter the anti-natalist perspectives on ART, particularly those of early radical feminists. A strand of liberal feminist writing in the 1970s and 1980s pleaded for “caring, connected, authentic, antiviolent stereotypes of motherhood,” strengthening arguments for “the return of agency to infertile women.”²⁰⁷ Liberal feminist scholars in the late 1980s and 1990s continued to take up this cause,²⁰⁸ crediting

depression score was still above average although fewer depressive symptoms were reported. Kraaij et al., *supra* note 201, at 9–10, 13–14. 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 to 2 years, then begin to feel hopeless during the second to third year, and finally start to resolve their feelings or move on to other alternatives . . .” Domar et al., *supra* note 199, at 1161.

206. Sandelowski, *supra* note 150, at 49.

207. Charis M. Thompson, *Fertile Ground: Feminists Theorize Infertility*, in *INFERTILITY AROUND THE GLOBE: NEW THINKING ON CHILDLESSNESS, GENDER, AND REPRODUCTIVE TECHNOLOGIES* 52, 61 (Marcia C. Inhorn & Frank van Balen eds., 2002).

208. See, e.g., Anne Woolett, *Infertility: From 'Inside/Out' to 'Outside/In'*, in *REPRESENTING THE OTHER: A FEMINISM & PSYCHOLOGY READER* 68, 68 (Sue Wilkinson & Celia Kitzinger

ART with the “potential to articulate new ways of embodying reproduction . . . refus[ing] to read new reproductive technologies as simply signing and sealing preexisting oppressive social orders.”²⁰⁹ They rejected the image of infertile women as coerced creatures because “there are no more introspective and self-conscious decision makers than couples compelled to find the way to parenthood.”²¹⁰ Further, several commentators have affirmatively argued that ART could empower patients in numerous ways.²¹¹

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.²¹² Recent liberal feminist scholarship develops more positive feminist images of infertile women, emphasizes that infertility is not an all-consuming condition, posits that stereotypes of desperation create caricatures of infertile women,²¹³ and recognizes motherhood's advantages and drawbacks.²¹⁴ This scholarship has helped to demonstrate that infertile women can desire children for reasons that appear anything but irrational.²¹⁵ After

eds., 1996) (discussing research that was “intended to represent infertile women whose voices and experiences . . . were omitted from current accounts of infertility”).

209. Thompson, *supra* note 173, at 64.

210. Sandelowski, *supra* note 150, at 43–44.

211. See, e.g., Rosalind Pollack Petchesky, *Foetal Images: The Power of Visual Culture in the Politics of Reproduction*, in REPRODUCTIVE TECHNOLOGIES: GENDER, MOTHERHOOD, AND MEDICINE 57, 72 (Michelle Stanworth ed., 1987) (“Like amniocentesis, in-vitro fertilization, voluntary sterilization and other ‘male-dominated’ reproductive technologies, ultrasound imaging in pregnancy seems to evoke in many women a sense of greater control and self-empowerment than they would have if left to ‘traditional’ methods or ‘nature.’”).

212. *Id.* at 66–67.

213. Gayle Letherby, *Challenging Dominant Discourses: Identity and Change and the Experience of ‘Infertility’ and ‘Involuntary Childlessness,’* 11 J. GENDER STUD. 277, 279 (2002) (stating that it is necessary to problematize the view that infertility becomes an individual's master status).

214. *Id.* at 285; see also Julia McQuillan et al., *The Importance of Motherhood Among Women in the Contemporary United States*, 22 GENDER & SOC'Y 477, 491–92 (2008) (analyzing the importance of motherhood among mothers and non-mothers, concluding that mothers can simultaneously value work and motherhood, and that the “importance of work and the importance of motherhood are positively correlated, and for non-mothers, there is no association,” debunking the notion that work-oriented women must be anti-child or that motherhood-oriented woman must be “anti-work”).

215. See Miriam Ulrich & Ann Weatherall, *Motherhood and Infertility: Viewing Motherhood Through the Lens of Infertility*, 10 FEMINISM & PSYCHOL. 323, 335 (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 a decisionmaking 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

interviewing infertile women about their treatment experiences, liberal feminist Gayle Letherby observed that respondents view desperation or obsession as only one aspect of their identities, and are people “with feelings of despair rather than ‘desperate people.’”²¹⁶ 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] felt that others were using this strategy.”²¹⁷ Moreover, emotional distress may be a “reasonable, rather than an irrational, response” to infertility if one is barren yet feels that the “mandate for motherhood [i]s compelling.”²¹⁸

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.²¹⁹ 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. We must continually and adamantly reject the notion that a woman’s desire to conceive is nothing but a coerced and therefore non-autonomous decision. Unfortunately, this idea has been fairly influential, reinforcing mainstream stereotypes and informing the more conventional feminist ideal of motherhood on women’s terms and timing.

Feminism 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

as a failure). *Id.* at 327–33. The authors concluded that a central theme of the accounts was “the importance of increasing awareness and support” for infertile women, “[t]he need to promote socially valued roles for women other than motherhood and the need to broaden what it means to ‘mother.’” *Id.* at 335.

216. Letherby, *supra* note 213, at 283.

217. *Id.* at 282.

218. Ulrich & Weatherall, *supra* note 215, at 334–35.

219. Sandelowski, *supra* note 150, 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.”).

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 their likely emotional, psychological, social, and financial consequences. Frustratingly, an infertile woman who is aware 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. Accordingly, overreliance on false consciousness theories forces women to trade patriarchal subordination for feminist oppression—a fact recognized by more contemporary liberal feminists.²²⁰

Limiting our focus to coercion and its role in reproductive decision making, however, is at once too simplistic and too broad. On occasion, we do restrict an individual's choices in order to enhance autonomy; for example, we protect employees from coercion by limiting the number of hours per day they may work, and we do not generally believe that such constraints are disrespectful. The reproductive choices that women considering fertility treatment face, however, are different in nature; the decision to reproduce and the freedom to choose how to reproduce are more fundamental to individual identity and personhood. The pressing questions, then, are not whether reproductive coercion exists or whether all reproductive choices are coerced, but why we tolerate some forms of coercion and not others, when restricting individuals' choices is an appropriate response to coercion and when it is not, and what other options we might have for reducing coercive influences other than decision-making constraints. Because reasoning and decision making are at the heart of autonomy, we may begin to answer these questions by considering more relational and reflexive conceptions of autonomy that acknowledge emotion's important contribution to decision making.

C. Reassessing Emotion's Role in Medical and Reproductive Decision Making

Analyzing contrasting constructions of women as reproductive decision makers also provides a case study of how we as social and cultural actors believe that it is appropriate to understand and negotiate the role of emotion in medical and reproductive decision making.

220. See, e.g., Sandelowski, *supra* note 150, at 39 (recognizing that “[r]eproductive technologies are tied to patriarchal concepts of womanhood,” while “[i]nfertile women also find themselves confronted with a group of feminists who suspect their motivations to procreate”).

The Supreme Court's abortion jurisprudence indicates that emotion has long been recognized as a vital part of assessing the pregnant woman's various options and of evaluating her social and relational positions. After *Gonzales v. Carhart*, certain negative emotions, most obviously regret, are now judged an inherent part of the abortion decision.²²¹ Foreclosing certain 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.²²² As previously discussed, feminist legal scholars and those who support a view of competent decision making that incorporates emotion counter these rulings by: (1) contending that women facing crisis pregnancies are capable and effective reproductive decision makers; (2) contending that emotion is an inherent part of not only an informed abortion decision but also of social and cultural judgments concerning the propriety of an abortion decision; and (3) acknowledging that the emotional characteristics of an abortion decision need not compel the normative judgment that women act irrationally or in a morally untrustworthy way when confronted with such emotionally charged decisions.²²³

In the infertility context, however, some legal scholars evaluate the emotion in ART 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.²²⁴ I dispute the conclusion that some women's desire—indeed, desperate need—to abort a crisis pregnancy is qualitatively different from the desire, or even desperate need, to conceive.²²⁵ 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. This Article attempts to extend legal scholars' contentions in the abortion context to the infertility setting by (1) asserting that infertile women are autonomous decision makers despite the fact that infertility and infertility treatment are emotional-

221. 550 U.S. 124, 159 (2007) (noting that the decision whether to have an abortion is "fraught with emotional consequence").

222. See *supra* Part II.B.1.

223. See *supra* Part II.B.2; see also Jeremy A. Blumenthal, *Abortion, Persuasion, and Emotion: Implications of Social Science Research on Emotion for Reading Casey*, 83 WASH. L. REV. 1, 28 (2008) (characterizing the argument that emotional factors bias women's decisions about abortion as "classically paternalistic").

224. See *supra* Part II.A.

225. See *infra* Part III.A–B.

ly challenging experiences that compel emotionally charged decisions, and (2) advocating a view of competent decision making that acknowledges the value of and incorporates emotional elements. I do not want to reject the notion of desperation itself, but rather the insinuation that desperation (and emotion in general) warps infertile women's decision-making competency; in other words, desperation—whatever its characteristics and however strongly it is felt—must be decoupled from irrationality.²²⁶

Incorporating emotion into theories of medical decision-making competence is a necessary step in recognizing infertile women as capable decision makers. In Western countries, competence is essentially seen as cognitive.²²⁷ Decisions made by competent individuals are to be respected because they are the product of circumspection; they are intellectual judgments that certain options are desirable because their potential outcomes increase well-being.²²⁸ 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. Thus, intervention in incompetent individuals' decision-making processes is more justifiable because those individuals cannot act in their own best interest.²²⁹ Significantly, “competence is decision-relative,” meaning that “[a] person may be competent to make a particular decision at a particular time, under certain circumstances, but incompetent to make another decision, or even the same decision, under different conditions.”²³⁰ The size of any incompetent group must be sharply limited because a declaration of incompetency is the most “profound infringement” of citizens' rights.²³¹

Adjudicating competency has largely fallen to common law courts,²³² which have enunciated and applied tests for determining competency that include several key capacities: “the abilities: to express a choice; to understand relevant information; to 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

226. See *infra* Part IV.

227. See, e.g., Charland, *supra* note 13, at 363–64 (noting that competence appears to be “primarily and exclusively a cognitive notion”).

228. Appelbaum, *supra* note 12, at 378.

229. *Id.*

230. ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 18 (1989).

231. Appelbaum, *supra* note 12, at 378.

232. *Id.*; see also Jessica Willen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345, 348–49 (1996) (noting that “in most jurisdictions only a court can decide if a person is incompetent”).

weighing options.”²³³ Appreciation, in particular, “refers to patients’ recognition that information given to them about their disorder and potential treatment is significant for and applicable to their own circumstances,”²³⁴ including not only understanding but applying abstract information on treatment risks and benefits to one’s own circumstances.²³⁵ This is typically seen as a primarily factual assessment related to intellectual capacity.²³⁶ 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.²³⁷ It is on the grounds of appreciation that ART scholars fault infertility patients’ decision making as the product of “denial, distortion, and delusions.”²³⁸

In contrast, numerous researchers have argued that medical decision-making competence is not entirely cognitive in nature and should be expanded to include patients’ emotional capacities.²³⁹ According to Joseph LeDoux, cognition and emotion are “separate but interacting mental functions” in numerous neurophysiological structures and activities.²⁴⁰ Emotions actually inform the decision-making process because they prompt patients to think through conflicting “first-order desires”²⁴¹ in line with closely held values.²⁴² Antonio Da-

233. Appelbaum, *supra* note 12, at 379; *see also* Berg et al., *supra* note 232, at 348–49.

234. Thomas Grisso et al., *The MacArthur Treatment Competence Study. II: Measures of Abilities Related to Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 127, 128 (1995).

235. Charland, *supra* note 13, at 363.

236. *Id.* at 362. *But see* BETTY COX WHITE, COMPETENCE TO CONSENT 71 (1994) (acknowledging that “the consensus is that competence to consent lies exclusively within the domain of the intellect,” but suggesting that an “exaggerated emphasis on the intellect . . . seems inadequate”).

237. THOMAS GRISSO & PAUL S. APPELBAUM, ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS 45 (1998) (emphasis removed). To qualify as a “failure of Appreciation,” the patient’s belief must also “be the consequences of impaired cognition or affect” and “be relevant to the patient’s treatment decision.” *Id.* at 47–48 (emphasis removed).

238. *See* Appelbaum, *supra* note 12, at 380 (discussing the views of scholars who disagree with a view of appreciation that “focus[es] exclusively on cognitive functions”).

239. *See, e.g.*, ANTONIO R. DAMASIO, DESCARTES’ ERROR: EMOTION, REASON, AND THE HUMAN BRAIN xii–xiii (1994) (suggesting that “emotion and feeling are indispensable for rationality”); RICHARD S. LAZARUS, EMOTION AND ADAPTATION 4, 6 (1991) (finding it “inconceivable” to divorce emotion from cognition); ROBERT C. SOLOMON, THE PASSIONS: THE MYTH AND NATURE OF HUMAN EMOTION 25–26 (1976) (seeking to “break down . . . unnecessary conflicts between reason and passions”); WHITE, *supra* note 236, at 70–71 (arguing that “mental function” incorporates both intellect and emotionality).

240. JOSEPH LEDOUX, THE EMOTIONAL BRAIN: THE MYSTERIOUS UNDERPINNINGS OF EMOTIONAL LIFE 68–69 (1996).

241. *See* WHITE, *supra* note 236, at 130–31 (“First-order desires are desires for something . . . (e.g., the desire for food).”).

242. *Id.* at 131, 137.

masio 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.²⁴³ Damasio's research suggests that frontal lobe damage cripples the human ability to consciously or unconsciously organize and utilize relevant past experiences and contemporary situational information, and therefore similarly cripples the ability to make competent decisions.²⁴⁴ Others assert that personal values guide patients' decisions, and observe that emotions are integral in evolving and discriminating among value systems.²⁴⁵ Therefore, as Louis 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?"²⁴⁶

Processes of appreciation, a central component of decision-making competence, also rely upon emotion.²⁴⁷ "[O]ne 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."²⁴⁸ This is an active, not a passive, task, involving a "negotiation" between an individual and her environment that is inherently involuntary, recursive, and revisionary.²⁴⁹

Borrowing from the work of Richard Lazarus, Terry 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

243. See DAMASIO, *supra* note 239, at 35–38, 54–58.

244. *Id.* at 38–39.

245. See BUCHANAN & BROCK, *supra* note 230, at 25 (asserting that "a competent decision-maker also requires a *set of values* or *conception of what is good*").

246. Charland, *supra* note 13, at 365.

247. *Id.* at 359–60.

248. *Id.* at 365–66 (discussing RICHARD S. LAZARUS & BERNICE N. LAZARUS, *PASSION AND REASON: MAKING SENSE OF OUR EMOTIONS* 143–45 (1994)).

249. *Id.* at 366.

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.²⁵⁰

Emotion, then, helps individuals to determine whether and how certain choices are personally meaningful, and thus aids the process of appreciating treatment effects and outcomes.²⁵¹

Finally, feminist philosopher Alison Jaggar’s research on “outlaw emotions” illustrates how emotion can aid decision making, enhancing individual autonomy.²⁵² According to Jaggar, we as members of particular societies and cultures absorb conventional standards and values (which usually benefit dominant social groups) to the point that they are “built into the foundation of our emotional constitution.”²⁵³ On occasion, however, individuals may escape these established patterns of emotional control when placed in problematic social situations in which they discover it is impossible to feel the conventional emotions they know they are “supposed” to experience.²⁵⁴ Jaggar proffers the example of a female employee who, when subjected to the catcalls of her male colleagues, feels uncomfortable or angry rather than flattered.²⁵⁵ Upon learning that others have had similar emotional experiences, the woman finds that her outlaw emotions are not so unusual after all, and realizes that “the basis exists for forming a subculture defined by perceptions, norms, and values that systematically oppose the prevailing perceptions, norms, and values.”²⁵⁶ Thus, “outlaw emotions may be politically (because

250. Terry A. Maroney, *Emotional Common Sense as Constitutional Law*, 62 VAND. L. REV. 851, 891–92 (2009) (footnotes omitted).

251. See WHITE, *supra* note 236, at 128–29 (“Persons relate present and preferred states of affairs to their well-being by paying attention to felt emotions and identifying whether or not those are preferred.”).

252. Alison M. Jaggar, *Love and Knowledge: Emotion in Feminist Epistemology*, in WOMEN, KNOWLEDGE, AND REALITY: EXPLORATIONS IN FEMINIST PHILOSOPHY 166, 180–84 (Ann Garry & Marilyn Pearsall eds., 2d ed. 1996).

253. *Id.* at 179.

254. *Id.* at 180.

255. *Id.*

256. *Id.*

epistemologically) subversive.”²⁵⁷ Outlaw emotions can challenge conventional ways of seeing the world, and may motivate new directions in critical research, leading to more complex, reflexive, and diversified perspectives on affairs.²⁵⁸ Thus, far from being debilitating, emotion is crucial to processes of evaluation and decision making; as Jaggar asserts, emotions are essential to knowledge no matter whether social convention labels them as appropriate or inappropriate:

Accepting the indispensability of appropriate emotions to knowledge means no more (and no less) than that discordant emotions should be attended to seriously and respectfully rather than condemned, ignored, discounted, or suppressed.

Just as appropriate emotions may contribute to the development of knowledge so the growth of knowledge may contribute to the development of appropriate emotions.²⁵⁹

Ultimately, the overall effect of acknowledging emotion's role in processes of knowledge production, including decision making, is enhanced moral and political individual autonomy.

Medical treatment choices are not appreciated fully unless an individual patient feels that these choices are personally significant.²⁶⁰ 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 emotive and existential senses of ‘utility.’”²⁶¹ What emotions might be particularly salient in a decision to seek fertility treatment? Fear, hope, determination, perseverance, and courage—all may be integral components of decision making, and are likely to be far more prevalent than extreme emotions such as desperation or obsession.

Of course, many critical and complex tasks lay ahead of us before we can determine if and in what way emotional capacity should become part of a model of competency. We need a clear definition of emotional capacity, reason to believe that emotional capacity can be defined and assessed, and a clear idea of what degree or type of impairment is our focus.²⁶² What constitutes a valid emotional test is a

257. *Id.*

258. *Id.* at 181.

259. *Id.* at 183.

260. Charland, *supra* note 13, at 368.

261. *Id.* at 369–70.

262. Appelbaum, *supra* note 12, at 384–85.

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 recognize the merits of considering how emotions can enhance as well as detract from an understanding of medical and reproductive decision making.

D. Reevaluating Rationality, Subjectivity, and Relational Autonomy in Assessing Competent Decision Making

Emotion is not just important in helping patients make medical decisions; it also plays a key role in how others evaluate those decisions 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.”²⁶³ This evaluator 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—is embedded.²⁶⁴ Benjamin Freedman identifies two ways in which a decision maker's reasons may fail the rationality test: (1) 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 (2) producing reasons, which although potentially true, fail to support the conclusion drawn—in short, *non sequiturs* (such as refusing surgery simply because it is Tuesday).²⁶⁵

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 evaluate and judge others for doing this very same thing. For example, we think it is illogical when smokers not only acknowledge smoking's health risks but overestimate them, and still make the ostensibly “irrational” deci-

263. See Benjamin Freedman, *Competence, Marginal and Otherwise: Concepts and Ethics*, 4 INT'L J.L. & PSYCHIATRY 53, 64 (1981) (asserting that “an individual is competent if he can supply rational reasons for his decision”).

264. *Id.* at 64–65.

265. *Id.* at 64.

sion to keep smoking.²⁶⁶ 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.²⁶⁷

Rationality thus provides an incomplete framework for this investigation into the evaluation of patients' medical decisions. Its insufficiency is underscored by the fact that law and emotion scholars and others have rejected a Cartesian or positivist dichotomy between emotion and reason.²⁶⁸ We should therefore pursue this inquiry outside of rationality's shaky structure in order to effectively consider other factors such as the relational positioning of the decision maker *vis-à-vis* the individual evaluating both herself and her decisions, the propriety of concentrating on negative emotions such as regret, the social impact of any alleged negative consequences of suboptimal ART decision making, and finally how best to derive more accurate and holistic conceptions of autonomy.

Let us begin by briefly explicating legal scholars' constructions of infertile women as “desperate” or “obsessed.”²⁶⁹ Perhaps Jaggar's concept of outlaw emotions might be useful here;²⁷⁰ it might be that society feels that infertile women *do* feel a form of desperation so profound that it threatens competency not only because women in particular *should* feel emotion, but also because they should feel it so acutely that it influences their decision-making processes to a degree incompatible with conventional positivist conceptions of a rational, competent decision. In a related sense, 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, so-

266. See W. KIP VISCUSI, *SMOKING: MAKING THE RISKY DECISION* 7, 19–21 (1992) (suggesting that while people tend to overestimate highly publicized smoking risks, they “will smoke more often than they should”).

267. See ELISA J. SOBO, *CHOOSING UNSAFE SEX: AIDS-RISK DENIAL AMONG DISADVANTAGED WOMEN* 25–26 (1995) (arguing that statistics show “[p]eople do have the facts [about HIV and AIDS], but they do very little with them”).

268. See, e.g., Kathryn Abrams & Hila Keren, *Who's Afraid of Law and the Emotions?*, 94 MINN. L. REV. 1997, 2003–12, 2027–33 (2010) (arguing in favor of the “*utility of analyzing the emotions* in responding to concrete legal problems”); Jeremy A. Blumenthal, *Emotional Paternalism*, 35 FLA. ST. U. L. REV. 1, 2–5 (2007) (suggesting that “emotional biases” are important “to legal decisionmaking”); Terry A. Maroney, *Law and Emotion: A Proposed Taxonomy of an Emerging Field*, 30 LAW & HUM. BEHAV. 119, 120–21 (2006) (noting that the study of law is becoming more receptive to issues of human emotion).

269. See *supra* Part II.A.

270. See *supra* text accompanying notes 252–259.

cialization, and other forms of casual empiricism.”²⁷¹ We rely on these common-sense ideas to help evaluate “the legitimacy and reliability of the information emotion imparts and the conclusions it compels.”²⁷² Our emotional common sense discloses much about our “affiliations, beliefs, and values,” as well as what “normative ends” we view as the proper outcome of a given situation; it “both colors interpretation of evidence and manifests in selective perspective-taking.”²⁷³

As Maroney indicates, individuals with differing emotional common sense will also prioritize different outcomes, and so “it is not possible to say one [view] is right and the other is not.”²⁷⁴ If emotional common sense is used to gauge the lived experience of others, especially those facing 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.²⁷⁵ 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.”²⁷⁶ 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 uncontested matters of fact.”²⁷⁷

Emotional common sense is also marked by “extraordinary inconsistency,” in that “[d]irectly opposing folk beliefs may be held simultaneously and will be selectively invoked”²⁷⁸ Maroney faults the majority in *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.”²⁷⁹ Thus, Maroney asserts:

271. Maroney, *supra* note 250, at 854.

272. *Id.* at 854–55.

273. *Id.* at 858.

274. *See id.* at 864–68 (noting that “[d]irectly opposing folk beliefs,” such as “haste makes waste” and “he who hesitates is lost” can both be “right,” because “common sense often will bear no relation to ‘truth’ in an absolute sense but instead will signal a person’s appraisal of the specific attributes of a situation as it relates to her own beliefs”).

275. *Id.* at 864.

276. *Id.* at 864, 866.

277. *Id.* at 902.

278. *Id.* at 866.

279. *Id.* at 889.

When the [Supreme] Court adopts 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.²⁸⁰

Maroney's analysis compels another question: what motivates scholars' concerns over infertile patients' decisions to proceed with fertility treatment? Is it because they perceive that these women are especially vulnerable? Or because they fear that these women may elect unadvisable choices, making "bad" financial decisions or assuming unnecessary health risks and procedures that they will come to rue? The exact reasons for concern have been left unspecified, but it is difficult to think of a more likely motivation than protecting infertile women 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 interest and that they will later lament.²⁸¹

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 option that one would have to be highly distressed—desperate—to accept.²⁸² But ART scholars' opinions reflect 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.²⁸³ But infertility patients clearly weigh these factors very differently, most likely according higher priority to the possibility of achieving conception.²⁸⁴ It is no wonder that these two groups have such markedly different views of the rationality of pursuing fertility treatment.

280. *Id.* at 901.

281. *See supra* text accompanying notes 42–47.

282. *See supra* text accompanying note 50.

283. *See supra* text accompanying note 58.

284. *See Sandelowski, supra* note 150, at 48 (stating that infertile couples prioritized trying to conceive and failing over not trying to conceive at all).

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.²⁸⁵ 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."²⁸⁶ 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 illustrate why this approach is inappropriate. Regret aversion occurs when a person makes a decision calculated to reduce the possibility of post-decision regret.²⁸⁷ After making a decision, the decision maker compares the actual end result to what she feels the end result would have been had she chosen differently; if she believes another choice would have led to a better outcome, then she will not only regret her decision, but will take estimations of regret into account when making future decisions to try to minimize her sense of regret.²⁸⁸ Empirical research has documented regret aversion in consumer purchases, doctors' and patients' medical decision making, adolescent sexual behavior, negotiation behavior, and gambling.²⁸⁹ Indeed, one study has concluded that IVF patients are motivated to undergo IVF to prevent feelings of regret.²⁹⁰ Behavioral law and economic scholars have asserted that regret aversion is a form of hindsight bias that, like other forms of cognitive bias, prompts people to make irrational decisions.²⁹¹ But if it is inappropriate for someone to make a decision

285. *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007).

286. Maroney, *supra* note 250, at 894.

287. Chris Guthrie, *Better Settle than Sorry: The Regret Aversion Theory of Litigation Behavior*, 1999 U. ILL. L. REV. 43, 69.

288. *Id.*

289. *Id.* at 70–72.

290. Tjeerd Tymstra, *The Imperative Character of Medical Technology and the Meaning of 'Anticipated Decision, Regret'*, 5 INT'L J. TECH. ASSESSMENT HEALTH CARE 207, 210–11 (1989).

291. See, e.g., 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, 1460, 1468, 1474–76 (2006) (defining cognitive biases as "subconscious mental processes that impair rational thought-processes and ultimately lead to 'irrational' choices"). One such cognitive bias is "hindsight bias," which "refers to the tendency of individuals to overestimate the extent

based on regret aversion, 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 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.²⁹²

Current constructions of infertile women's "desperation" or "obsession"²⁹³ to conceive a child mischaracterize 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 indicate 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, such as a desire to conceive children (which may include having a child biologically related to one or both parents) or a yearning for the experience of gestating and giving birth to a child, among other goals. Reasons for pursuing treatment stem from a combination of factors that include both emotional and non-emotional components—indeed, the very same combination of desires, values, and factual, non-subjective 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.

to which they anticipated the fruition of a particular event." McCann asserts that the effects of hindsight bias are exacerbated by regret aversion. *Id.* at 1475.

292. In Huxley's novel, Soma is a pleasure drug that the World State government uses to maintain control over its citizens. ALDOUS HUXLEY, *BRAVE NEW WORLD* 53–54 (Harper Perennial 2006) (1932).

293. *See supra* Part II.A.

Of course, the risks faced by cancer patients and infertility patients are by no means the same; cancer patients unquestionably face more dire outcomes 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 the beholder. Having to choose between treating a disorder or admitting that a cherished goal—be it living or conceiving—is unattainable inspires so many 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.”²⁹⁴ A study led by Dr. Maurice L. Slevin, consultant physician at St. Bartholomew's and Homerton Hospitals in London, reports that patients' attitudes likely change dramatically upon a 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 “appear[] to regard a minute chance of possible benefit as worth while, whatever the cost.”²⁹⁵ Yet, 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 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.²⁹⁶

If one extends this study's conclusions to infertility, the resulting scholarship might not be so much a lesson about desperation, obsession, or irrational decision making as it would be about changes in values due to a perceived crisis and ensuing changes in treatment perspectives. There is a difference between being an outsider looking into the experience of cancer or infertility, and an insider who must make decisions to deal with these diagnoses. Odds of success offer

294. Maurice L. Slevin et al., *Attitudes to Chemotherapy: Comparing Views of Patients with Cancer with Those of Doctors, Nurses, and General Public*, 300 BRIT. MED. J. 1458, 1459 (1990).

295. *Id.* at 1460.

296. *Id.* There has been some attention focused, however, on how cancer patients' emotional vulnerabilities affect their decisionmaking abilities. See, e.g., James Rickert, Letter to the Editor, *Cancer Care: Deciding Where to Go*, N.Y. TIMES, Dec. 28, 2009, at A26; Natasha Singer, *Cancer Center Ads, Appealing to Emotions at a Fragile Time*, N.Y. TIMES, Dec. 19, 2009, at A1.

the potential for hope, however thin. If cancer patients who prioritize 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 they may achieve their goal?

The side effects of IVF are much less serious than those associated with chemotherapy, and IVF has fairly good chances of success for many, if not most, patients, and these odds are continuously improving with technological advances in reproductive medicine.²⁹⁷ 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—most of us—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 inherently rational or irrational in an infertile woman's decision to seek medical treatment. Like decisions made in other medical contexts by individuals whose competence is not questioned, it surely merits a strong presumption of rationality. Instead, construing infertile women's decisions to undergo treatment entails making subjective cultural judgments as to what kinds of desires deserve protection, and thus, necessarily, of whom we should protect.

A more detailed focus on autonomy also begs the question of who exactly is affected if the decision maker were to make a suboptimal choice; the more people who are negatively affected or harmed by the choice, the more compelling the need for social concern over the decision-making processes, and the more justified potential state regulation.²⁹⁸ A reproductive decision that only affects the decision maker adversely is necessarily different from a decision that has negative implications on society as a whole. One possible exercise is to contrast the societal impact of a pregnant woman's potential failure to appreciate the nature of an abortion decision with the societal impact of an infertile woman's potential failure to understand what is at stake in pursuing fertility treatment.

Let us assume for a moment the opposite of what I (and other legal scholars and social scientists in the abortion context) have argued thus far—that women often fail to appreciate the consequences

297. *See supra* text accompanying note 182.

298. *Cf.* Jerry Ellig, *The Economics of Regulatory Takings*, 46 S.C. L. REV. 595, 599 (1995) (discussing government regulation of negative externalities from an economic standpoint).

of an abortion decision.²⁹⁹ From a “pro-life” perspective, this failure could lead to at least two types of externalities: women choosing abortion would have a negative emotional experience such as regret or trauma,³⁰⁰ and the decision would violate a moral baseline that some assume is universal.³⁰¹ Both of these externalities are arguably invalid. A woman’s negative emotional experience is not a true externality because she makes the decision based (at least in part) on an internal assessment of how the abortion will affect her, and because she personally experiences these consequences. In addition, the morality externality is invalid because it is difficult to successfully argue that a universal moral baseline exists in contemporary American society.

There appears to be a greater societal impact with respect to a woman’s failure to appreciate the nature of decision making in infertility treatment. Let us again assume the truth of a position rejected by this Article—that infertile women often fail to appreciate the nature of ART treatment decisions. In this context, others may have to share or bear the high financial and social costs of multiple pregnancies and premature births, as well as the consequences of predatory providers who either manipulate success rates by cherry-picking patients or who accurately state success rates but do not inform patients with certain conditions that their IVF cycles will likely fail. Here, however, a societal response would not have to be predicated on an infertile women’s failures as a decision maker or on her “irrationality” and need not even entail state regulation; instead, these issues can be (and currently are) addressed through other means such as medical board sanctions, legal claims involving fraud and malpractice,³⁰² professional medical association guidelines,³⁰³ and health insurance restrictions such as limits on numbers of embryos transferred in a cycle. Crucially, as in the abortion context, the remaining (emotional and financial) consequences are largely borne by the infertile woman or

299. *See supra* Part II.B.1.

300. *See supra* text accompanying notes 94–99.

301. *See supra* text accompanying note 109.

302. Physicians administering IVF treatment are “under the normal constraints of standard malpractice and tort liability.” Note, *supra* note 53, at 2103. Notably, however, “proving fraud or malpractice when a program presents somewhat misleading success-rate data may be difficult: the information is not an outright lie, but only an overly optimistic presentation of accurate data.” *Id.*

303. For example, the American Society for Reproductive Medicine (“ASRM”) established the Society for Assisted Reproductive Technology (“SART”) in 1984 “as a kind of Phi Beta Kappa of IVF practitioners.” *Id.* at 2104 (citation and internal quotation marks omitted). Most IVF programs in the United States are members of SART, which sets forth minimum guidelines and statistical reporting requirements in order to be a member. *Id.* at 2104 n.69.

the infertile couple. Although these consequences may be suboptimal from a societal standpoint, American society permits its citizens to make any number of suboptimal decisions as to how to spend their money and seek fulfillment (for example, by smoking or gambling), and it is difficult to see why infertility treatment should be any different.

This societal impact analysis provides an argument against foreclosing certain choices altogether, not against all forms of regulation. One may envision many forms that ART regulatory schemes could take. Some regulations would inevitably be explicitly autonomy-enhancing, such as requirements that improve the quality of decision making through mandating that clinics provide patients with certain types of information, abide by informed consent regulations, and even provide informational counseling. Notably, these autonomy-enhancing obligations are imposed mostly upon institutions such as doctors and clinics, and not infertile patients themselves. Other regulations could be autonomy-assessing, in the sense that they mandate various means of evaluating individuals to see if they are truly making autonomous decisions, such as counseling that gauges infertility patients' reasons for obtaining treatment.³⁰⁴ Nonetheless, we should be suspicious of autonomy-assessing restrictions because they may limit individuals' choices. These regulations are thus potentially problematic but also necessary in some circumstances. Finally, regulatory schemes could be autonomy-restricting by foreclosing certain choices altogether. For instance, a state could enact a provision restricting the numbers of embryos that can be transferred in one IVF cycle. Ideally, these provisions should be somewhat flexible and based on medical necessity rather than hard and fast limitations on practitioner and patient autonomy.³⁰⁵ A provision restricting the number of embryos transferred in one IVF cycle to the amount medically necessary is infinitely preferable to a strict limitation of two embryos per IVF cycle, which could tie the hands of both doctors and patients. Of

304. See ABA MODEL ACT GOVERNING ASSISTED REPROD. TECH. § 302(d) (2008) (requiring that “[t]he intended parents have undergone a mental health evaluation to determine their suitability to participate in collaborative reproduction” before undergoing certain ART procedures).

305. The ASRM and SART have issued model guidelines to assist ART programs in determining the appropriate number of embryos to transfer per IVF cycle. AM. SOC'Y FOR REPROD. MED. & SOC'Y FOR ASSISTED REPROD. TECH., *Guidelines on Number of Embryos Transferred*, 92 FERTILITY & STERILITY 1518, 1518 (2009). The guidelines are based on the success rates of individual programs, the age of the patient, the age of the donor, the quality of the embryos, and the number of previous treatments the patient has undergone, among other factors. *Id.* at 1518–19. Further, the guidelines allow for modification based on individual circumstances and needs. *Id.* at 1518.

course, there will inevitably be extreme cases, such as that of Nadya Suleman, that may warrant both autonomy-assessing and autonomy-restricting regulations.

It is important to acknowledge that people will at times make reproductive decisions that many others perceive as “bad” or “irrational.” These decisions may even be ones that the decision makers themselves will come to regret. But this inevitability is inherent in the nature of human decision making and individual autonomy; imperfect humans will not always make perfect choices. A suboptimal decision is not necessarily an incompetent decision, and democratic ideals compel extreme caution before we foreclose citizens’ ability to make certain choices for themselves. We must 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 the 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 have the autonomy to make those decisions, and that we accurately conceptualize autonomy so as to guarantee and maximize this freedom of choice.

To these ends, we should reject a conventional individualistic conception of autonomy in favor of a more relational model of autonomy. Most conventional models of autonomy, including legal definitions of competence, favor an individualistic perspective on autonomy that prioritizes a person’s competency, which includes both soundness of mind and ability to make decisions free of coercion.³⁰⁶ The focus here is not so much upon what decision an individual makes as it is upon her right to make the decision.³⁰⁷ Here, the decision maker is seen as distinct from communal and social influence.³⁰⁸ Legal scholars who construe infertile women as desperate individuals whose decision-making processes are warped by emotional influence largely rely upon this individualistic perspective, which is not surpris-

306. See SHEILA A. M. MCLEAN, *AUTONOMY, CONSENT AND THE LAW* 17–20 (2010) (describing the traditional legal view of autonomy as one in which “[t]he individual is supreme, and once judged competent is entitled to make decisions on the basis of his or her own concerns and interests, subject only to the caveat that they do not harm third parties.”); SUSAN H. WILLIAMS, *TRUTH, AUTONOMY, AND SPEECH: FEMINIST THEORY AND THE FIRST AMENDMENT* 42 (2004) (describing the traditional model of autonomy as one that requires choices to be made in the absence of coercion to be considered autonomous). For the most comprehensive discussion of relational autonomy, see JENNIFER NEDELSKY, *LAW’S RELATIONS: A RELATIONAL THEORY OF SELF, AUTONOMY, AND LAW* (2011).

307. See MCLEAN, *supra* note 306, at 20; WILLIAMS, *supra* note 306, at 42.

308. MCLEAN, *supra* note 306, at 20; WILLIAMS, *supra* note 306, at 42–44.

ing given the dominance of this model in conventional legal thought and jurisprudence.

A relational model of autonomy, however, recognizes that individuals as decision makers are embedded in social relations.³⁰⁹ The autonomous person “recognises his or her inter-relationship with the society of which s/he is a part and is able to acknowledge that his or her choices are socially constructed and have consequences for the community.”³¹⁰ Autonomy is possible *through*, not *despite*, social interaction.³¹¹ The relational perspective of autonomy acknowledges that individuals do not just make decisions on the basis of their own values and desires; there are “reasonable (and ethically justifiable) constraints on the excessive selfishness that individualistic autonomy would . . . have few, if any, means of preventing.”³¹² Autonomous decisions are precisely those that the decision maker acknowledges are influenced by social obligations and responsibilities important to the decision maker.³¹³ Adopting a relational model of autonomy is an important step in acknowledging and accommodating emotion's contributions to decision making.

Finally, empirical research on exactly how and why infertile women make decisions in ART is an essential component of revising conventional understandings of emotion's role in decision making and conceptions of autonomy. To date, no qualitative or quantitative research has examined infertility patients' actual informed consent experiences (though this author is currently involved in such a project). Research on informed consent for medical procedures other than ART paints a dismal picture, finding evidence for poor patient comprehension of informed consent documents,³¹⁴ patients who base medical decisions on fear, emotion, and religious beliefs instead of medically accurate information,³¹⁵ and patients who prefer to defer to treating physicians' recommendations rather than become extensively informed about the details and risks of clinical care or intimate-

309. MCLEAN, *supra* note 306, at 21.

310. *Id.*

311. *Id.*

312. *Id.* at 23.

313. *Id.*

314. See, e.g., Sanja Kusec et al., *Improving Comprehension of Informed Consent*, 60 PATIENT EDUC. & COUNS. 294, 298–99 (2006).

315. Dan W. Brock & Steven A. Wartman, *When Competent Patients Make Irrational Choices*, 322 NEW ENG. J. MED. 1595, 1598 (1990).

ly included in medical decision making.³¹⁶ 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.³¹⁷ Yet it is highly likely that typical informed consent concerns (low comprehension or decision making based on inadequate information) do 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.³¹⁸ 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.

IV. 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, or reinforce paternalistic attitudes toward women and reproductive decision making.

Legal scholars' constructions of infertile women, their emotions, and their decision-making processes have important practical consequences. Scholars' concern over the timing and pervasiveness of psychological distress and therefore the absence of decision-making capacity is wide of the mark.³¹⁹ 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 effect upon decision making before the first

316. Kusec et al., *supra* note 314, at 297–99. See also Andrea D. Gurmankin et al., *Patients' Resistance to Risk Information in Genetic Counseling for BRCA1/2*, 165 ARCH INTERNAL MED. 523, 523 (2005).

317. See, e.g., Waldman, *supra* note 17, at 922–24 (“Patients beset by strong hopes and anxieties have difficulty absorbing medical information and rationally evaluating the risks and benefits of various treatment options.”).

318. See Margaret Ann Mille, *The Fertility Center of Sarasota is One of About 350 Clinics Nationwide Using Technology to Help Women Have Babies*, SARASOTA HERALD-TRIBUNE, Oct. 23, 2000, Business Weekly Section, at 1 (discussing the high cost of IVF—which averages between \$8,000 to \$10,000 per attempt—and the attendant access problems for low-income women).

319. See *supra* Part II.A.

treatment cycle begins.³²⁰ Assessments of infertile women's mental health are currently mandated, if at all, by industry guidelines and model acts.³²¹ The American Society of Reproductive Medicine guidelines recommend that fertility clinic personnel include a "consultant/mental health professional with expertise in reproductive issues,"³²² 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."³²³ In addition, the American Bar Association Model Act Governing Assisted Reproductive Technology ("Model Act") provides that all ART patients must undergo an initial "mental health consultation," which entails 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."³²⁴ The Model Act further provides that "[d]uring the consultation, the provider must offer additional counseling to each participant;" however, the participant is not required to accept additional counseling.³²⁵ 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, be notified of the availability of additional voluntary counseling, and provided 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, intrusive, and inefficient mental health inquiries. Psychological evaluations are in danger of morphing into assessments of parental fitness, since distress could prompt labels anti-

320. See *supra* text accompanying notes 196–197.

321. Charles P. Kindregan, Jr. & Steven H. Snyder, *Clarifying the Law of ART: The New American Bar Association Model Act Governing Assisted Reproductive Technology*, 42 FAM. L.Q. 203, 203 (2008).

322. Am. Soc'y for Reprod. Med., *Revised Minimum Standards for Practices Offering Assisted Reproductive Technologies*, 90 FERTILITY & STERILITY S165, S165 (3d Supp. 2008), available at [http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/Revised_minimum_standards\(1\).pdf](http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/Revised_minimum_standards(1).pdf).

323. Kindregan & Snyder, *supra* note 321, at 216–17.

324. ABA MODEL ACT GOVERNING ASSISTED REPROD. TECHNOLOGY § 301(1) (2008).

325. *Id.* § 301(2). The Model Act also enumerates the qualifications necessary to be a "mental health professional," and states that the result of the consultation may not be used to arbitrarily deny patients the right to procreate. *Id.* §§ 301(3), 301(1).

thetical to society's conception of "fit" potential parents: individuals who are stable, rational, and able to utilize sound judgment.³²⁶

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 hysteric. References to desperate infertile women and couples have acquired great cultural significance.³²⁷ Such stock narratives evolve into background cultural assumptions, and may be used as shortcuts when interpreting events and communicating ideas to others, working their way into judicial opinions, legislative regulation, and legal scholarship.³²⁸ 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, scholars have proffered alternative constructions of pregnant women, abortion, and reproductive decision making that emphasize bodily integrity, self-autonomy and accountability.³²⁹

Current constructions of infertile women as desperate, unreasonable, or incapable of informed consent are influential stock narratives that others impose on infertile women.³³⁰ These discursive formations are dangerous as they are absorbed into institutions and

326. See Kindregan & Snyder, *supra* note 321, at 217 ("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.").

327. 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"); Sarah Franklin, *Deconstructing 'Desperateness': The Social Construction of Infertility in Popular Representations of New Reproductive Technologies*, in *THE NEW REPRODUCTIVE TECHNOLOGIES* 200, 203-04, 216 (Maureen McNeil et al. 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, *Bloggng Infertility*, *THE NEW ATLANTIS* 79, 81 (2008), available at <http://www.thenewatlantis.com/publications/bloggng-infertility> (quoting infertility blogger "Bea," who wrote, "[t]he number of times the word 'desperate' headlines an article on infertility is appalling," and Tertia, who agreed, "I hate the way the media portrays infertiles as sad, desperate women . . .").

328. 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, 97-98 (2004).

329. See *supra* Part II.B.2.

330. Letherby, *supra* note 213, at 286.

individuals' lives, and resonate with other negative images of infertile women in popular culture, which already is populated with such stereotypes that are based on traditional patriarchal views.³³¹ In contemporary media, women famous for conceiving multiples after fertility treatment are portrayed as "irresponsible, narcissistic, possibly mentally unstable and, above all else, selfish."³³² Kate Gosselin, mother to the twins and sextuplets featured on the popular Learning Channel reality show *Jon and Kate Plus 8*, has been variously described as bitchy, potentially unstable, greedy, and willing to sacrifice her children's well-being for money and fame.³³³ Older women³³⁴ and young single women who conceive through IVF also have earned public criticism.³³⁵ "Octomom" Nadya Suleman has been repeatedly declared desperate and emotionally or mentally unstable.³³⁶

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 regulations on ART. A legal academic construction would therefore reinforce and legitimate mainstream social stereotypes, 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

331. *Id.*

332. Marlo Campbell, *The Baby Trap: Women Must Give Birth, Except When They Shouldn't*, WINNIPEG FREE PRESS, Feb. 17, 2009, at A15, available at 2009 WLNR 3132976.

333. See, e.g., James Poniewozik, *Balloon Boy's Lesson: The New American Dream*, TIME, Nov. 2, 2009, available at <http://www.time.com/time/magazine/article/0,9171,1931740,00.html>; *Kate Gosselin is a Bitch*, THE BLEMISH (Aug. 11, 2009, 10:35 AM), <http://theblemish.com/2009/08/kate-gosselin-is-a-bitch/>.

334. Ranjit Hayer, who conceived twins through IVF at 60, is just one of several older women to be publicly vilified after undergoing IVF. Campbell, *supra* note 332. See also Laura Donnelly, *At 66, Is This Woman Too Old to Have a Baby*, SUNDAY TELEGRAPH (UK), May 17, 2009, at 20, available at 2009 WLNR 9384005; Andrew Levy, *Mother-to-be, 66, Began IVF Five Years Ago*, DAILY MAIL (UK), May 18, 2009, available at 2009 WLNR 9452486; *Doctor Defends IVF for Woman, 62*, BBC NEWS (May 4, 2006, 2:15 PM), <http://news.bbc.co.uk/go/pr/fr/-/2/hi/health/4971930.stm>.

335. Single women undergoing IVF are seen as newsworthy. See, e.g., Beezy Marsh, "Bio-Panic" Sees Twice as Many Single Women Try for IVF Babies, TELEGRAPH (UK), Oct. 8, 2006, at 11, available at 2006 WLNR 17428001.

336. E.g., Jon Carroll, *Doctors and Drug Companies—Our Friends?*, S.F. CHRON., March 9, 2009, at E10; Tracy Connor, *Lonely Childhood Spawned Octuplet Wish*, N.Y. DAILY NEWS, Feb. 4, 2009, at 10; Joanna Weiss, *Family Drama*, BOS. GLOBE, Feb. 7, 2009, at G26; Kimi Yoshino et al., *It's All Just So Octo-licious: Nadya Suleman Can't Seem to Get Enough Kids, and Media Audiences Can't Seem to Get Enough of Her*, L.A. TIMES, Feb. 28, 2009, at A1.

remain so forever.³³⁷ Part and parcel of developing an effective regulatory scheme will be identifying the fundamental values on which policies will be based, and scholarship must respond effectively to these stereotypes in order to prevent the law from reflecting them. 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 success, given the success/failure reporting requirements of federal law.³³⁸ Fertility clinics in turn have redirected the blame toward patients, claiming that parents would prefer twins to decrease costs and complete a family in a single pregnancy.³³⁹ Emphasis on the limits of maternal decision making may open the door to more extensive regulation; if the legislation is part of a woman-blaming exercise rather than a realistic assessment of the commercial marketplace, the result may ultimately be unrealistic and 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 re-

337. See June Carbone & Naomi Cahn, *Embryo Fundamentalism*, 18 WM. & MARY BILL RTS. J. 1015, 1015 (2010) (noting, "As use of ART has increased, so have calls for supervision and oversight.").

338. See *id.* at 1019; Naomi R. Cahn & Jennifer M. Collins, *Eight is Enough*, 103 NW. L. REV. COLLOQUY 501, 510 n.43 (2009).

339. See, e.g., David Orentlicher, *Multiple Embryo Transfers: Time for Policy*, HASTINGS CENTER REP. May-June 2010, at 13 (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."); Ginny L. Ryan et al., *The Desire of Infertile Patients for Multiple Births*, 81 FERTILITY & STERILITY 500, 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, Oct. 11, 2009 (stating "many women undergoing in-vitro prefer to have twins"); Miranda Hitti, *Twins in Demand Through IVF*, WEBMD, available at <http://www.webmd.com/baby/features/twins-demand-through-ivf> (last visited Feb. 21, 2012) ("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.").

search.³⁴⁰ Claude Steele and Joshua 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.³⁴¹ Stereotype threats may apply to any stigmatized group and are situation-specific.³⁴² 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.³⁴³ It is not necessary that a group member internalize or even believe a stereotype for a stereotype threat to occur; the group member need only know that the stereotype exists and is applicable in a social situation.³⁴⁴

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 also mental dysfunction, even for fertile women undergoing treatment 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 2009 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.³⁴⁵ Clinical researchers have noted that the correlation between women’s psychological and emotional adaptation to infertility and infertility treatment puts an additional burden on them simply because it suggests that women’s adaptation strategies can influence treatment outcome, “inadvertently perpetuat[ing] the myth that

340. Claude M. Steele & Joshua Aronson, *Stereotype Threat and the Intellectual Test Performance of African Americans*, 69 J. PERSONALITY & SOC. PSYCHOL. 797, 797–98 (1995).

341. *Id.* at 797.

342. *Id.*

343. *Id.*

344. *Id.* at 798. See also David M. Marx, Joseph L. Brown & Claude M. Steele, *Allport’s Legacy and The Situational Press of Stereotypes*, 55 J. OF SOC. ISSUES 491, 492 (1999) (discussing expectancy theory, which posits that the perception of one’s own reputation impacts one’s behavior and beliefs).

345. A. D. Domar et al., *The Impact of Group Mind/Body Participation on Pregnancy Rates in IVF Patients: A Randomized Controlled Trial*, 92 FERTILITY & STERILITY S2, S2 (2009). See also *New Study Reveals Link Between Stress Reduction and Increased Fertility*, INSCIENCES ORGANISATION (Oct. 19, 2009, 8:47 AM), http://insciences.org/article.php?article_id=7220.

women, directly or indirectly, are the main source of infertility problems.”³⁴⁶

Moreover, these stereotypes may encourage infertile women and couples to subconsciously suppress stress in order to distance themselves from such negative images.³⁴⁷ This may be detrimental to treatment outcome because “[s]tress can be considered a ‘healthy’ reaction (i.e., it is healthy to feel stressed in stressful situations), and it is a person’s style of coping with stressful situations that seems to be important in maintaining health.”³⁴⁸ Patients who feel that they cannot openly acknowledge their stress and distress are deprived of this significant coping mechanism. Thus, this stereotype threat makes an already stressful experience even more taxing and may discourage advantageous coping practices, lowering odds of conception and enabling the invidious stereotype of infertile women as incapable decision makers to more directly affect the distribution of life opportunities—the chances to conceive, birth, and raise children.

Furthermore, stereotype threat may foster a culture of emotional deceit instead of emotional candor. Koen Demyttenaere notes that “patients with infertility usually present with suppressed stress levels because they tend more than other patients to give socially desirable answers because they are afraid of being denied further treatment.”³⁴⁹ Other researchers have also concluded that infertility patients play roles they deem most appropriate, either exaggerating “desperation” to enhance access to treatment³⁵⁰ or not admitting to distress during counseling.³⁵¹ There is little doubt that these constructions exert profound influence; Letherby reports that her infertile respondents are

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 them³⁵²

346. Koen Demyttenaere et al., *Coping Style and Depression Level Influence Outcome in In Vitro Fertilization*, 69 FERTILITY & STERILITY 1033 (1998).

347. *Id.* at 1027.

348. *Id.*

349. *Id.* See also F. P. Haseltine et al., *Psychological Interviews in Screening Couples Undergoing In Vitro Fertilization*, 422 ANNALS OF THE N.Y. ACAD. OF SCI. 515 (1985) (stating that women obtaining fertility treatment are “reluctant to report their stress for fear that they will be dropped from the protocol or that they might be ‘jinxed.’”).

350. Letherby, *supra* note 213, at 282.

351. Klein, *supra* note 150, at 162.

352. Letherby, *supra* note 213, at 286.

Patients could attempt to behave hyperrationally in order to distance themselves from mainstream cultural assumptions wedding infertility to desperation and desperation to irrationality. This undermines patients' ability to make autonomous decisions in two ways. First, it undermines the trust and open communication integral to an effective patient-physician relationship by rendering it harder for patients to freely acknowledge and discuss fears, stress, and distress with their physicians. As a result, patients may obtain less information crucial to autonomous decision making. Second, it makes it more difficult for clinic staff to identify outlier cases in which patients are experiencing clinical distress, and thus complicates their obligation to fulfill informed consent obligations. Under these conditions, it is doubtful whether practitioners can accurately assess patients' mental and emotional health during counseling sessions.

On a related note, infertile women may also feel that they must comport with gendered stereotypes of the "ideal" infertility patient in order to obtain fertility treatment. Social scientists have observed that infertility patients "display 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"³⁵³ Empirical research also suggests that an assertive infertile woman who either passively fails to comport with existing mainstream stereotypes or actively challenges negative characterizations could be labeled by clinic personnel as "difficult" and "uncooperative," and could even be refused treatment.³⁵⁴ Clinicians can determine who is and is not an ART candidate, placing the infertility patient "in the position of an object of scrutiny and classification by the physician."³⁵⁵ After asking infertility physicians in Finnish public and private infertility clinics how they formed impressions of female patients, Maili Malin concluded 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."³⁵⁶ Malin's respondents asserted that state of health, including mental state, is the initial factor in IVF patient selection.³⁵⁷ Self-confident, urban,

353. Thompson, *supra* note 207, at 65.

354. See Maili Malin, *Good, Bad and Troublesome: Infertility Physicians' Perceptions of Women Patients*, 10 EUR. J. WOMEN'S STUD. 301, 306 (2003) (observing that "[v]ery wealthy, career-oriented people were seen to be difficult patients and less good parents to be.").

355. *Id.* at 302.

356. *Id.*

357. *Id.* at 304.

upper class patients, “assertive consumers of medical treatment,” were seen as threats and disliked because they questioned physicians’ authority.³⁵⁸ 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.”³⁵⁹

In addition, infertile women may be unlikely to challenge inaccurate constructions, since doing so might expose them to social isolation. For example, women who abort often do not feel comfortable informing others of their abortion to avoid social stigma:³⁶⁰ “[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.”³⁶¹ Furthermore, “[c]oncealing an abortion may prevent the loss of important social networks and preserve social support.”³⁶² While perhaps less stigmatized than abortion, infertility treatments are still controversial,³⁶³ and admitting to infertility treatment is arguably stigmatizing and establishes one as “other.”³⁶⁴ Infertile women’s supposed emotionality may degrade the perceived quality and value of their critical voices, diluting their influence.

Finally, stereotype threat also implicates another issue—researchers of stigmatizing conditions often do not belong to such groups and therefore assume theoretical perspectives “uninformed by

358. *Id.* at 307.

359. *Id.* at 312.

360. See, e.g., Jane Greenway, *Abortion—Ending the Taboo*, 18 BRIT. J. OF NURSING 714, 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. PSYCHOL. 735, 735 (1999) (“Women who have had an abortion often do keep it a secret from others [M]ost 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.”) (citations omitted).

361. Major & Gramzow, *supra* note 360, at 735.

362. *Id.* at 736.

363. Scholars have been arguing since the early 1980s that infertility is a stigmatizing status and a taboo social subject. See NAOMI PFEFFER & A. WOOLLETT, *THE EXPERIENCE OF INFERTILITY* 81, 82 (1983).

364. 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 & J. Levy eds., 1991); Letherby, *supra* note 213, 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.’ . . . [I]t 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.’”).

the lived experience of the people they study.”³⁶⁵ The result is that researchers may unwittingly misunderstand and misrepresent the lived experiences of stigmatized group members and maintain unsubstantiated assumptions.³⁶⁶

For better or worse, “reproductive medical practices and discourses are an exercise in moral and social control.”³⁶⁷ 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.³⁶⁸ The best solution is not prohibiting ART but empowering infertile women. Two important steps toward more informed constructions of infertile women are 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.

V. CONCLUSION: FROM WOMAN SCORNED TO WOMAN COMPETENT

While clinical research recognizes that infertility can be emotionally distressing,³⁶⁹ legal scholars have added additional and unnecessary normative overlays to craft demeaning constructions of infertile women as emotional to the point of irrationality.³⁷⁰ 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 children³⁷¹ diminishes the scho-

365. Bruce G. Link & Jo C. Phelan, *Conceptualizing Stigma*, 27 ANN. REV. SOC. 363, 365 (2001).

366. *Id.* at 365.

367. Malin, *supra* note 354, at 313.

368. *See id.* at 302 (“Doctors tend to inscribe certain value attributes to their patients, and their judgments materialize in the form of patient selection and treatment manners.”).

369. *See supra* Part III.A.

370. *See supra* Part II.A.

371. *See* Naomi Pfeffer, *Artificial Insemination, In-vitro Fertilization and the Stigma of Infertility*, in REPRODUCTIVE TECHNOLOGIES: GENDER, MOTHERHOOD, AND MEDICINE 81, 82 (Michelle Stanworth ed., 1987) (“The word desperation or some such synonym appears so frequently in conjunction with infertility . . .”); *see also* Sarah Franklin, *Deconstructing ‘Desperateness’: The Social Construction of Infertility in Popular Representations of New Reproductive Technologies*, in THE NEW REPRODUCTIVE TECHNOLOGIES 200, 218 (Maureen McNeil, Ian Varcoe & Steven Yearley eds., 1990) (“It is the tremendous scope of their personal and social loss which is said to account for the ‘desperateness’ of infertility.”).

larly inquiry into the infertility experience and portrays these women as creatures driven by blind instinct rather than as autonomous persons with the will and capacity to pursue identified life goals, including medical treatment.³⁷²

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.³⁷³ 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.³⁷⁴ 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.³⁷⁵ Reproductive decision making is not just a veto on unwanted pregnancies; it encompasses the choice to conceive as well as the choice to not give birth.³⁷⁶ In both cases, the determinations are deeply personal and political, involving emotions and bodily integrity, and they deserve the utmost respect. Challenging and rehabilitating the portrayal of infertile women in legal scholarship is a powerful first step toward 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."³⁷⁷

Exposing the damaging institutional and individual consequences of perpetuating inaccurate infertile women stereotypes is the first step toward evolving more accurate and empowering characterizations.³⁷⁸ Scholars must be extremely cautious about how law—and legal arguments—construct legal actors, lest academic efforts in-

372. *See supra* text accompanying notes 363–366.

373. *See supra* Part III.B.

374. *See supra* Part II.A.

375. *See supra* Part III.C.

376. *See supra* Part III.B.

377. Michelle Stanworth, *Reproductive Technologies and the Deconstruction of Motherhood*, in *REPRODUCTIVE TECHNOLOGIES: GENDER, MOTHERHOOD, AND MEDICINE* 1, 35 (Michelle Stanworth ed., 1987).

378. *See supra* Part IV.

tended 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 *ideology*, with significant ramifications in the broader context of women's rights. As Jennifer Nedelsky notes, to "routinely require special protective measures will not actually enhance women's equality or autonomy. It keeps them in a kind of subordinate relationship requiring protection."³⁷⁹

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.³⁸⁰ After all, "[c]ompelling ideas, once unleashed and so influential as to become almost invisible, may be like tides that can sometimes take us to surprising places."³⁸¹ Aggressive efforts to change such conceptions are underway in the abortion context, where these perceptions are enshrined in legal policy.³⁸² The struggle must continue in scholarship addressing infertility.

In actuality, infertility is not a "master status"—the social factor that is an individual's primary identifying characteristic.³⁸³ One's life does not stop with a diagnosis of infertility—bills must be paid, jobs performed, social obligations upheld, life lived—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.³⁸⁴ This dedication may not be something that others—members of the "fertile world"—can easily understand or appreciate.

379. NEDELSKY, *supra* note 306, at 69.

380. Suk, *supra* note 161, at 1231.

381. *Id.* at 1201.

382. *See supra* Part III.C.

383. Letherby, *supra* note 213, at 279 (stating that it is necessary to problematize the view that infertility becomes an individual's master status).

384. *See supra* text accompanying notes 183–184.

Nor do doctors usually welcome patients' intense scrutiny into procedures and success rates.³⁸⁵

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.”³⁸⁶

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.³⁸⁷ 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, then they are not. And others will abrogate their right to think.

385. *See supra* text accompanying notes 338–339.

386. Ulrich & Weatherall, *supra* note 215, at 335.

387. *See supra* Part III.B.