2011

THE MORE THINGS CHANGE ... : ABORTION POLITICS & THE REGULATION OF ASSISTED REPRODUCTIVE TECHNOLOGY

Beth Burkstrand-Reid

University of Nebraska-Lincoln, bburkstrand-reid2@unl.edu

Follow this and additional works at: http://digitalcommons.unl.edu/lawfacpub

Part of the Legal Studies Commons

Burkstrand-Reid, Beth, "THE MORE THINGS CHANGE ... : ABORTION POLITICS & THE REGULATION OF ASSISTED REPRODUCTIVE TECHNOLOGY" (2011). College of Law, Faculty Publications. 77.
http://digitalcommons.unl.edu/lawfacpub/77

This Article is brought to you for free and open access by the Law College of at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in College of Law, Faculty Publications by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.
Abortion and assisted reproductive technology ("ART") may seem paradoxical in reproductive health: a woman seeks to terminate a pregnancy in the first, while a woman goes through herculean attempts to attain one in the latter. In fact, they share fundamental concerns: women’s health and autonomy. Both include medical procedures, with potential health risks and benefits, and both help a woman choose whether and when to become a mother. Abortion and ART share another commonality: when these issues enter public and political discourse, consideration of women’s health often recedes into the background.

This response to the articles by June Carbone and Jody Lynée Madeira suggests that issues central to the development of abortion-related regulation and jurisprudence have the potential to drive the development of ART and related law. First, like abortion, ART is available to a limited number of women.
Abortion restrictions weigh most heavily on women of lesser financial means, for whom ART is also largely unavailable. Second, if new reproductive technology spurs greater regulation, as it has in the abortion context, that regulation may be driven by politics in lieu of or in addition to true health concerns. To an extent, this is already occurring. Ideologies influence the regulation of embryo destruction, a core issue in ART, just as they do with abortion and its attendant "informed consent" requirements. In neither context is women's health—or her reproductive autonomy—the central concern.

Part I of this article briefly explains the technology at issue in the articles by Carbone and Madeira and summarizes the central points of each. Part II describes how ART regulation may mirror abortion-related regulations. Part III concludes by discussing potential public policy implications of the relationship between these aspects of women's reproductive health.

I. CARBONE'S AND MADEIRA'S CONTRIBUTIONS

Carbone's and Madeira's articles focus on advancing ART, paying particular attention to a new procedure through which doctors may be able to create an egg with mitochondrial DNA from one woman and nuclear DNA from the fertilized egg of another in hopes of achieving a pregnancy and, subsequently, a child. The intervention used to address mitochondrial DNA defects relies on techniques, broadly construed, similar to those involved in cloning. According to Carbone, it uses the same process involved to produce a clone—transfer of a
nucleus from one cell to another—but, because mitochondrial DNA therapy uses the nucleus of a fertilized egg rather than the nucleus of a somatic cell from an existing adult, the procedure involves fewer developmental risks to a resulting fetus.\textsuperscript{12} It is for this reason—the direct connection to the hot-button issue of human cloning—that this particular technique has the potential to galvanize public opinion in a way similar to abortion.\textsuperscript{13}

Carbone suggests that, given the lack of oversight of ART, a fundamental decision looms: should the use and development of ART be regulated or should it be allowed to evolve with little oversight?\textsuperscript{14} In posing that question, she raises issues central to many reproductive health issues, abortion included: should technologies that may present risks to women’s health be permitted, restricted or banned, and by whom should that decision be made?\textsuperscript{15} Are market forces adequate to address thorny ethical and medical questions presented by the medical treatment, or should other regulatory regimes respond to the questions presented by new technology?\textsuperscript{16} Carbone asserts that public regulation carries with it at least three possible risks: (1) the prospect of discrimination against non-traditional families,\textsuperscript{17} (2) the possibility of technologies being abandoned due to politically motivated bans or to the cost of development,\textsuperscript{18} and (3) its potential impact on service availability and cost.\textsuperscript{19} Some of the risks Carbone identifies in the context of ART regulation have already been realized in the abortion context: limited availability of services because of service cost, geographically constrained availability, limited insurance coverage and public funding, and bans or restrictions on certain procedures motivated by concern for the fetus (even when those actions threaten maternal health and autonomy).\textsuperscript{20} Ultimately, Carbone concludes that the future of a regulatory regime governing ART is difficult to predict.\textsuperscript{21} She hypothesizes, however, that political forces make regulation unlikely in the absence of individual state action or international pressure to address compelling health risks.\textsuperscript{22} Short of federal regulation, she predicts that private norms will likely fill the regulatory void because fertility tourism makes state regulations relatively

\textsuperscript{12} Carbone, supra note 3, at 9-10 & n.58.
\textsuperscript{13} According to Carbone, cloning is controversial for many reasons, and the majority of those reasons fall into three main categories: first, cloning raises the specter of “unnatural” human beings; second, embryo destruction is likely to be part of the nuclear transfer process; and third, genuine concerns about safety arise from the unregulated scientific research in this arena. Id.
\textsuperscript{14} Id. at 15.
\textsuperscript{15} Id. at 22-23.
\textsuperscript{17} Id. at 23-24.
\textsuperscript{18} Id. at 16.
\textsuperscript{19} Id. at 13.
\textsuperscript{20} See generally Burkstrand-Reid, supra note 2.
\textsuperscript{21} Carbone, supra note 3, at 27.
\textsuperscript{22} Id. at 26.
easy to evade for those with the financial means. This outcome is not without its concerns, as private norms are neither universally applied nor enforced. Madeira focuses on the emotional attachment couples form to their embryos and whether that attachment changes in particular ART contexts. Specifically, Madeira examines the emotional attachments that may form to “excess” embryos and whether new technologies, most notably cytoplasm donations and pronuclear transfer, might change how couples treat the decisions related to their excess embryos. As part of her research, she highlights the significance of emotional bonding to early developing embryos seen via ultrasound (which, as we will see in the case of abortion, may be compelled by regulation). The article concludes with some irony, however, that emotional attachment combined with altruistic motives for donation in the IVF context may motivate greater interest in donation so that some part of the embryo will live on, a concept that runs counter to motivations in the abortion context.

Together, the articles suggest that women may be eager to take advantage of new reproductive technology but that the industry is devoid of regulations to ensure women’s safety or public monies to broaden access to it.

II. ABORTION AND ART: STORIES IN SIMILARITIES?

There are many parallels between the issues that confront abortion and assisted reproduction. Given that ART is the proverbial new kid on the block, it may be abortion that shows it the ropes. The notable similarities between abortion regulation, mitochondrial DNA therapy and, more generally, ART suggests that emerging ART techniques have the potential to fundamentally change the nature and timing of when women become “mothers,” socially and legally. Specifically, expanding ART techniques raises important questions about the availability of these services and how they will be regulated and to what end.

A. Accessibility

An obvious—yet still weighty—issue that emerged in the abortion debate and is equally as relevant in the context of ART is the availability of the medical procedures at issue. While there is need for both abortion and infertility

\[23\] Id. at 26.
\[24\] Madeira, supra note 4.
\[25\] Id. at 4.
\[26\] Id. at 5 & n. 27.
\[27\] Id. at 17.
\[28\] Whether an embryo should have (or has) rights in personhood is not a central concern of Carbone and Madeira’s articles. Nonetheless it has been raised vis-à-vis the abortion debate. See, e.g., Christina Zampus & Jaime M. Gher, Abortion as a Human Right—International and Regional Standards, 8 HUM. RTS. L. REV. 249, 266-67 (2008) (noting the similarities between embryonic right-to-life claims and pro-life claims in the abortion realm).
treatment, similar forces threaten the availability of each. The ability to access abortion and ART is constricted by geographic location and financial means.\textsuperscript{29} Given that availability of ART is already limited, additional regulation that affects such services—directly or indirectly—has the potential to further harm women.

Both abortion and fertility treatment are needed health services for women nationwide, yet their availability is geographically restricted.\textsuperscript{30} Abortion is unavailable or of limited availability for a significant portion of women simply because of where they live.\textsuperscript{31} Almost half of all pregnancies in the United States are unintended; forty percent of unintended pregnancies are aborted and twenty-two percent of all pregnancies (miscarriages excluded) end by abortion.\textsuperscript{32} Still, the availability of abortion services in the United States is limited when looked at on a county-by-county basis: in 2005, eighty-seven percent of all U.S. counties—including more than one-third of all American women—had no abortion provider.\textsuperscript{33} Similarly, the availability of assisted reproductive health technology providers is geographically constrained: clinics are heavily clustered on the coasts and several states have only one or no clinics.\textsuperscript{34} This lack of availability exists despite the fact that in one single year, approximately 1.2 million women sought fertility-related medical assistance.\textsuperscript{35} (Undoubtedly, many more women needed, but could not access, ART and abortion services.)

Geography is only an issue, of course, for those women who do not have the means to seek services far away from where they live. For those unable to travel, ART (and abortion) is not only bounded by geography but also by cost. “In 2005, the cost of a nonhospital abortion with local anesthesia at 10 weeks’ gestation ranged from $90 to $1,800; the average amount paid was $413.”\textsuperscript{36} Almost half “of women obtaining abortions have incomes below 100% of the federal poverty level ($10,830 for a single woman with no children). Twenty-seven percent of women obtaining abortions have incomes between 100-199% of the federal poverty level.”\textsuperscript{37} ART takes the issue of cost to a different level. By one estimate, a single cycle of in vitro fertilization, for example, costs between


\textsuperscript{31} Guttmacher Institute, \textit{An Overview of Abortion in the United States}, supra note 30.

\textsuperscript{32} Id.

\textsuperscript{33} Id.

\textsuperscript{34} 2007 ART REPORT, supra note 30. The CDC estimates that slightly more than one percent of all live births in the U.S. were conceived via ART. Id.


\textsuperscript{36} Guttmacher Institute, \textit{An Overview of Abortion in the United States}, supra note 30.

\textsuperscript{37} See id.
$7,000 and $11,000. This cost puts infertility services simply beyond the means of many women: one study suggested that "financial access is the most serious barrier to seeking and receiving [infertility] treatment." Availability—simply from a socioeconomic standpoint—is limited for both services.

Additionally, ART may face a tipping point of public opinion that pushes it into broad and deep public regulation, as did abortion. For abortion, that tipping point was arguably the "partial-birth" abortion debate. So-called "partial-birth" abortion galvanized the abortion-rights debate by focusing on what was presented as one procedure that accomplished its ends through particularly gruesome means. The possibility that one aspect of ART—the fact that ART uses cloning-analogous technology—could become a tipping point in the debate is not far-fetched. As Madeira suggests, the word "clone," which sometimes arises in the context of ART, makes people nervous, to say the least. A cloning-related technology, with its potential to conjure gruesome (even if inaccurate) words and images, could, like "partial-birth" abortion, quickly galvanize public opinion against ART, thus bringing increased regulation (and decreased availability) to fruition. That push-back on availability could come in the form of limitations on insurance coverage or public funding of services. And, as Carbone warns, increased regulation in the United States could drive some people to seek certain ART services overseas, further widening the divide.

40 Carbone, supra note 3, at 36.
41 Or, it may in fact be that the vitriolic abortion debate has diverted attention from ART, allowing it to prosper with little oversight. See, e.g., Brenda Reddix-Smalls, Assessing the Market for Human Reproductive Tissue Alienability: Why Can We Sell Our Eggs But Not Our Livers?, 10 Vand. J. Ent. & Tech. L. 643, 676 (2008).
43 See Rosato, supra note 5, at 73-75. Publicity surrounding multigestational pregnancies like that of "Octomom" Nadya Suleman and Kate Gosselin of Jon & Kate Plus 8 could have been a tipping point, but most efforts to regulate implantation of multiple embryos have been defeated. See, e.g., Cahn & Collins, supra note 29; Carbone & Cahn, supra note 5, at 1041-45 (discussing state legislative attempts at ART regulation).
44 Carbone, supra note 3, at 9.
46 See, e.g., Carbone & Cahn, supra note 5, at 1032-33 (asserting ART funding suffers from the same divisive issues as abortion); Guttmacher Institute, Restricting Insurance Coverage of Abortion As of Aug. 1, 2010, http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf (describing regulation of insurance covering abortion services).
47 Carbone, supra note 3, at 24 n.122.
between those wealthy enough to access medical care abroad and those for whom the procedures are financially unavailable.

Once the morality-based regulatory door is wide open, regulations too numerous to count may come to fruition. For example, restrictions on ART may be passed purportedly to protect the health of the fetus or woman, but in reality they may restrict availability in a way that threatens women’s health, as is the case in the abortion context. Limited availability of abortion and ART procedures threaten women’s health and reproductive autonomy now. Contemplating the similarities between abortion and ART brings into sharp focus the potential future of availability of ART.

B. “Informed” consent

Assuming that a more comprehensive regulatory system is imposed on ART, lawmakers may borrow extensively from abortion regulation as both technologies (1) involve medical procedures that (2) concern irresolvable moral debates about when life begins and that (3) women of varying demographics seek to access. ART regulation, if it is based even partially on abortion regulation, may include targeted regulation of ART facilities, limitations on types of procedures, when they are available and to whom, and a host of other measures designed either to protect women or to promote a political agenda, depending upon your point of view. One still-evolving abortion regulation that merits scrutiny in terms of its possible applicability to ART is what some call “informed consent” laws.

Many states require that women hear, read or be presented with state-authored information prior to an abortion; this information varies by state, but may include suggestions that women suffer mental health consequences, that the fetus feels pain during the procedure, and even erroneous information that

48 Some scholars, however, think that abortion politics have actually caused the lack of ART regulation. Alicia Ouellette et al., Lessons Across the Pond: Assisted Reproductive Technology in the United Kingdom and the United States, 31 AM. J.L. & MED. 419, 433 (2005).


51 The many individual ways in which abortion regulation may be co-opted by anti-assisted reproduction activists is vast. For a comprehensive list of abortion regulation in the United States, see GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: AN OVERVIEW OF ABORTION LAWS (Oct. 1, 2010), http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf; see also Harper Jean Tobin, Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws, 17 COLUM. J. GENDER & L. 111 (2008) (asserting that information on fetal pain presented to women seeking abortion is unconstitutional).
abortion is linked with cancer.\textsuperscript{52} Some lawmakers and anti-abortion rights activists call these "informed consent" requirements, while abortion rights advocates call them "biased counseling."\textsuperscript{53} "Informed consent" laws, when combined with mandatory waiting periods before a woman can have an abortion, increase the gestational age of the fetus and therefore increase the health risks to the pregnant woman and the costs of the procedure.\textsuperscript{54}

Traditional abortion-related "informed consent" regulations, accomplished via paper handouts given to a patient or a conversation held with a medical professional, have been augmented with a newer, more creative (and arguably ideologically-motivated) "informed consent" technique which requires no written words, only an image.\textsuperscript{55} Twenty states have regulations that promote the use of ultrasounds as a form of "informed consent," ostensibly with the aim of discouraging abortion.\textsuperscript{56} Some of these states require abortion providers to perform an ultrasound on a woman and offer her the opportunity to see it prior to termination; others require the same if the abortion is to be performed after the first trimester; still others require physicians who perform an ultrasound to offer to describe the ultrasound to the woman; and even more variations on ultrasound-related laws exist.\textsuperscript{57} In Oklahoma, for example, a law was passed mandating that, at least one hour prior to an abortion, the physician show the woman an ultrasound image of the fetus while simultaneously describing the heartbeat and the size of any visible organs; although the woman could refuse to look, she would still be forced to listen to the physician's description.\textsuperscript{58}

\textsuperscript{52} Id.
\textsuperscript{56} This is not to suggest that medically-driven ideologically neutral informed consent has no place in ART. See DAAR, supra note 2, at 701-03 (discussing informed consent guidance from the American Society for Reproductive Medicine).
\textsuperscript{58} GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: REQUIREMENTS FOR ULTRASOUND, supra note 57.
Unnecessary ultrasounds add to the cost of abortion, and, when combined with mandatory waiting periods, increase the time it takes to access abortion services, possibly negatively impacting women's health.60 "Since routine ultrasound is not considered medically necessary as a component of first-trimester abortion, the requirements appear to be a veiled attempt to personify the fetus and dissuade a woman from obtaining an abortion."61

What does ultrasound in the abortion context have to do with ART? A great deal. Both use pictures in an attempt to define the start of "motherhood" with many potential consequences.62 In the abortion context, "technology and the practice of ultrasound have transformed the fetus from potential life to something that can have its picture taken" a step "perhaps as close to a marker of personhood as one can get."63 Pre-abortion ultrasound is a transparent attempt to force motherhood on a woman who has chosen not to accept that role at that time.64 In ART, as Madeira explains, "[f]ertility clinics foster emotional connection to embryos by giving intended mothers pictures of transferred embryos and by encouraging them to watch the transplantation procedure on an ultrasound screen—and perhaps even giving them an ultrasound picture of the newly-transferred embryos 'at home' in the uterus."65

There are differences in ultrasounds in these contexts, however. First, a woman viewing a pre-abortion ultrasound may see a fetus, while a woman viewing an ART-related ultrasound sees much less.66 Moreover, the manner in which ultrasounds are used in the abortion context is an overt attempt by the state to coerce women into becoming mothers.67 As doctors in fertility centers undoubtedly must know, showing a woman a picture of an embryo can induce a woman to feel like a mother instantaneously.68 Any coercion in the context of ART, if it exists at all, is much less apparent.69 And, in the fertility context is

---

61 GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: REQUIREMENTS FOR ULTRASOUND, supra note 57.
62 Sanger, supra note 57, at 379-93.
63 Id. at 379.
64 See generally id.
65 Madeira, supra note 4, at 5.
67 See Corbin, supra note 59, at 998-1011 and accompanying notes (noting that the most effective ultrasound in the first trimester requires a probe be inserted in the pregnant woman's vagina).
68 As Michelle Goodwin points out, ART is "romanticized through photographic imagery . . . Images of happy, middle class white parents, sometimes with their new families, give an unrealistic illustration of ART." Goodwin, supra note 2, at 40.
69 And in fact, it is unclear that coercion exists at all. As Madeira says, ART patients want to get pregnant. Madeira, supra note 4, at 14-15. Coercion may come in, however, when determining how many embryos to transfer.
certainly not state-mandated and is done in the context of trying to achieve a birth, not ending one—though this could certainly change.

Nonetheless, the use of ultrasounds, when examined together in both contexts, demonstrates that regulations, technology and context can be combined to alter the way in which women define themselves—as mothers or not. Aside from expanding the use of ultrasound technology, ART regulations may capitalize on this demonstrated connectivity in other ways. Will the purpose of further informed consent in ART be used to preserve embryonic life, to prevent it or both? In the abortion context, in 2007, for example, South Carolina considered requiring women to view ultrasound images prior to having an abortion.\(^7\) Similarly, might the state require women to look at the eggs or embryos to further foster maternal attachment? This is not a question without real-world implications; such a policy has the potential to decrease selective reduction, deter destruction of “excess” embryos or discourage termination in the presence of fetal defects.

III. BROADER IMPLICATIONS

Today, whether and when a woman becomes a mother is both an individual and a public determination.\(^7\) Regardless of whether it is abortion or ART, there is a strong social desire to control women’s decisions regarding pregnancy and motherhood.

As previously mentioned, in the context of ART, the technology itself—including ultrasound—has the ability to push the point of motherhood back, even, as Madeira acknowledges, to a point prior to conception, thereby propelling ART advocates to recognize “life” extremely early.\(^7\) As Madeira points out, the vast array of issues that motherhood (or potential motherhood) presents in the context of ART are based both on the woman’s emotional attachment to the embryo at issue and efforts by physicians to foster attachment at earliest stages of

ART procedures. Women (and their physicians and advocates) may identify themselves as a mother prior to conception.

In the abortion context, women are also encouraged (if not coerced) to accept the role of "mother" at an early stage of pregnancy. This is accomplished by state regulations, including ultrasound requirements, designed to foster emotional attachment to the fetus. However, unlike women using ART, women seeking abortion (and their advocates) likely will try to push "motherhood" further into the future. This suggests that women may become opposing forces, unwittingly working against one another and potentially decreasing women's reproductive health services, which has the potential to be bad for all women. Any individual woman might need fertility services, abortion services or both, either during the same pregnancy (e.g. selective reduction of fetuses in the case of multifetal pregnancies) or at different times in her life.

Moreover, while the availability of ART should increase the number of women who can conceive, when turned on its head, the availability (or future requirement) of ART-related genetic testing prior to conception may actually reduce the pool of women who become mothers. ART may produce an expanded ability to determine prenatal fetal defects and ultimately lead to such testing being required, either by private norms or by public regulation, in any pregnancy—ART conceived or not. As is the case with any genetic testing, by requiring women to see themselves as mothers at such an early point, women hypothetically may be discouraged or prohibited from pregnancy. As Madeira discusses, assisted reproductive technologies such as pronuclear transfer may compel a "good" mother to use genetic testing to determine her genetic suitability for motherhood. It is a safe assumption that some women, armed with the knowledge that there are genetic issues that may complicate pregnancy or childrearing, will forgo childbearing. This may especially be the case given recent legislature proposals that would allow doctors to limit the communication of information about potential birth defects in order to prevent abortion. A law passed in Oklahoma would grant physicians who do not inform prospective parents that a fetus has birth defects immunity from malpractice suits. Assuming that a woman desires and is able to mother to begin with, mandatory genetic testing, ultrasounds, abortion regulation, and tort immunity may, in fact,

---

73 See Madeira, supra note 4, at 5.
75 Andrews, supra note 72, at 972 (saying that the lower risks of a newer prenatal diagnosis technique may lead to mandated testing). Some clinics are planning on using pre-implantation genetic diagnosis to allow prospective parents to choose their children's traits. See, e.g., Gautam Naik, A Baby, Please. Blond, Freckles—Hold the Colic, WALL ST. J., Feb. 12, 2009, at A10, available at http://online.wsj.com/article/SB123439771603075099.html.
76 See Madeira, supra note 4, at 2.
stop abortion—but also may decrease pregnancy. Therefore, expanding ART techniques and related testing—technologies that are meant to increase the pool of parents, regardless of conception method—may, in the end, contract it.

IV. CONCLUSION

Comparing abortion and ART—especially controversial techniques like cytoplasm donation—may be detrimental to both. Each technology forces society to confront the deepest issues concerning the beginning of life and, for women, forces them to consider when motherhood begins and what responsibilities might flow from it. Abortion rights advocates must push the inception of motherhood to a point as late in the gestational process as possible so as to avoid thorny issues of fetal personhood. Fertility doctors and their patients may have just as strong of an interest in recognizing an earlier start to motherhood, as a way of gaining or preserving hope during a fragile and unpredictable process. Regardless of when motherhood begins for these women, as abortion and ART regulation continue to grow, women may be further required to subrogate their choices and their health to public determinations of when a woman should or does becomes a mother.

78 A doctor who “caused” a pregnancy by implanting an embryo with a known defect might present a very different situation.